Today's Date_____

FORD EYE CARE CENTER

NEW PATIENT INFORMATION

Last Name_____ First _____ MI _____

Mailing Address _____City _____ State _____

Zip Code _____ Preferred Language _____ Race _____

Social Security # _____ (Required unless payment is cash)

Primary Phone _____Alternate Phone:_____

Date of Birth _____ Sex_____ Marital Status_____

Student: Full time or part time Occupation_____Employer_____

Driver's License # _____E-mail_____

Whom may we thank for referring you _____Communication preference: phone ☐ mail ☐ e-mail ☐

I am interested in: GLASSES CONTACTS LASIK OTHER_____

INSURANCE MEMBER INFORMATION

Insurance Company _____ ID# _____ Group# _____

Policy Holders' Name _____ Birth Date_____ Sex _____

Address_____

Primary Phone _____ Alternate Phone:_____

Relationship of Patient to Policy Holder: Self ☐ Spouse ☐ Dependant ☐

Policy Holder Social Security #_____ (Required to file insurance)

RESPONSIBLE PARTY (Must be filled out of patient is under 18 years old)

Last Name_____ First _____ MI _____

Mailing Address _____E-mail_____

City _____ State _____ Zip Code _____

Primary Phone _____ Alternate Phone_____

Date of Birth _____ Sex_____ Relation to Patient_____

Social Security # _____ (Required unless payment is cash)

EVER TREATED OR DIAGNOSED FOR THE FOLLOWING? (Please circle all that apply & explain)

Cataracts ☐	Iritis/Uveitis ☐	Allergies ☐	Heart Condition ☐	High Blood Pressure ☐
Corneal Abrasion ☐	Lazy Eye ☐	Asthma ☐	High Cholesterol ☐	Kidney Condition ☐
Eye Infection ☐	Macular Degeneration ☐	Arthritis ☐	Retinal Detachment ☐	Thyroid Condition ☐
Eye Injury ☐	Cancer ☐	Diabetes ☐	Retinal Tear ☐	Glaucoma ☐

_____

_____

_____

EVER EXPERIENCE ANY OF THE FOLLOWING EYE CONDITIONS? (Please circle all that apply)

Blurry Vision ☐	Flashes of Light ☐	Sunlight Sensitivity ☐	Floaters/Spots ☐
Burning ☐	Crossed Eye/Eye Turns ☐	Tearing ☐	Grittiness ☐
Double Vision ☐	Headaches ☐	Itchiness ☐	Trouble seeing at night ☐

IS THERE A FAMILY HISTORY OF ANY OF THE FOLLOWING?

	Relationship
Blindness	_____
Cataracts	_____
Corneal Problems	_____
Glaucoma	_____
Lazy Eye	_____
Macular Degeneration	_____
Retinal Problems	_____
Diabetes	_____
Heart Disease	_____

Please list any problems regarding your eyes (past or present)

_____

_____

Please list any health issues

_____

_____

Please list medications

_____

_____

PAYMENT POLICY Exam fees, co-payments, deductibles, and non-covered tests or materials are due at the time of service. Contacts lenses must be paid for at the time of ordering. Glasses must have a deposit of 50% (half of the total cost) upon order, with the balance due upon dispense.

If we are a provider for your insurance and you have coverage for service and/or materials, we will submit claims for you. Because of the uniqueness of carriers and individual policies, we may not always know the extent of coverage, and they may not provide coverage for some materials/services. Therefore, we are not liable for collecting your claim. After 30 days, we will expect payment in full if your insurance carrier has not paid.

ACKNOWLEDGEMENT I hereby authorize my insurance carrier to make direct payment to Ford Eye Care Center for service rendered. I understand that I am fully responsible for any and all charges, whether or not covered by insurance.

I give my consent for any information regarding my treatment or condition to be released in order to obtain payment for professional services. I am aware that Dr. Ford's NOTICE OF PRIVACY PRACTICES is posted at the front desk and I may obtain a copy upon request.

Returned checks will incur a $30 service fee. I am aware that if my account is not paid within 30 days of service, it may be sent to collections. I assume all legal fees and service charges incurred if collection action must be taken. I have read & agree to the statement above:

SIGNATURE _____DATE: _____

Ford Eye Care Center

Bret Ford, O.D.
714 Hill Country Drive
Kerrville, TX 78028
830/315-3673(FORD)

In an effort to provide our patients with the best care possible we have incorporated state of the art technology using the Visual Field Analyzer and Optomap Retinal Imaging. Unfortunately, routine eye exams may not detect many diseases in their early stages.

The Visual Field Analyzer detects loss of vision that can be signs of diseases such as pituitary tumor, glaucoma, retinal and macular degeneration, optic nerve disease, or retinal disturbances due to vascular problems or medication.

Thru fundus photography, the Optomap can detect retinal problems such as holes, tears, detachments, tumors, macular degeneration, and retinal hemorrhages. This can often take the place of dilation, therefore there are no side effects of dilation and it is less expensive.

Dr. Ford highly recommends that all of our patients receive both evaluations. He feels they are an integral part of your exam. It is especially important for those who have a history of high blood pressure, diabetes, headaches, migraines, floaters, a high spectacle prescription, retinal problems, or have a family member which suffers from glaucoma or retinal problems.

The fee for the Visual Field is $99.00 and is covered by most major medical insurance plans if there is a medical diagnosis. If you do not have insurance you will receive a professional courtesy and your fee will be $25.00.

The fee for the Optomap is $74.00 and is covered by most major medical insurance plans if there is a medical diagnosis. If you do not have insurance you will receive a professional courtesy and your fee will be $49.00.

Please check the appropriate choice and sign below:

☐ I would **like** to include the Visual Field Analyzer in my exam.

☐ I would **like** to include the Optomap Retinal Imaging in my exam.

☐ I am **declining** the above testing. I understand the importance of additional testing and will not hold Dr. Ford or his staff responsible for any undetected eye health issues that may arise.

Patient Name_____

Signature _____ Date _____

SUBMIT APPLICATION