OceanOptics

Today's Date _____
Last Name _____
First Name _____
Street _____
City _____ State _____ Zip _____
Home Phone _____
Work Phone _____
Cell Phone _____
Date of Birth _____ Gender: M F
Height _____ Weight _____
Patient's SSN _____
Employer (or school) _____
Occupation (or grade) _____
Emergency Contact Name _____
Emergency Contact Phone _____
Email Address _____

What is the main purpose of this visit?

If you are a ***new patient*** , who referred you to our office?
Name of friend, relative or physician:

If not referred, how did you choose our office for your eyecare?
____Insurance ____Internet
____Other: ___ _____

How would you prefer to be contacted? (Check all that apply)

__Phone call __Email
__Other:_____

DILATION

Dilation of the pupils is the only way to have a thorough and complete eye examination. It allows your optometrist to obtain a better view inside your eyes in order to ensure optimal eye health. For this reason, it is required by law of this State to be a part of all first-time routine exams. ***There is no additional charge for this procedure.***

Dilation may temporarily result in blurred vision and sensitivity to light for about two to four hours. Sunglasses will be provided. If you are not prepared at this time to be dilated, please check the appropriate line below and sign your name.

___ I wish to have a complete exam including dilation
___ I wish to have a complete exam, but would like to reschedule the dilation. I understand that there may be diseases, defects, lesions or other problems that were not examined or ruled out today; and as a result, I do not hold Kandace Haines, O.D., Ocean Optics of Delray Beach, Inc. or its associates liable for any delay in diagnosis and treatment that may have resulted from my deferring dilation today. I understand that it is my responsibility to reschedule this portion of the exam.

_____ _____
Patient Signature Date

REFRACTION

If you want to know if a new pair of glasses will improve your vision, then a test called a REFRACTION must be done. Under **Federal Law**, we are **REQUIRED** to charge for this test. Please note that some vision plans **MAY** include a refraction. Should you choose to have the refraction done in this office, this charge of $35 is payable at the time of service.

I undertand that the REFRACTION is a NON-COVERED service and that I am responsible for the payment of the fee AT THE TIME OF SERVICE. Please Initial _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependant) have insurance coverage and assign directly to Kandace Haines, O.D and Ocean Optics, Inc all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am responsible for all co-pays and/or co-insurance. I also undertand that in the event that my insurance does not remit payment, I am responsible for any charges incurred. I understand that I am financially responsible for all charges whether or not paid by insurance. I, hereby, authorize the doctor to release all information necessary to secure the payment of benefits and authorize the use of my signature of all insurance submissions.

_____ _____
Responsible Party Signature Date

Relationship: _____