Piedmont EyeCare Associates, OD, PLLC

A MEMBER OF VISION SOURCE

Piedmont EyeCare Associate
Welcome To Our Office

Welcome to Piedmont EyeCare Associates. Thank you for choosing us for your eyecare needs. We are delighted to have you as a patient and appreciate the confidence you placed in us. Please take a moment to complete the following information. If you have any questions, please do not hesitate to ask.

HEALTH HISTORY

What is the main reason for today's exam? _____

When was your last exam? _____

When was your last health exam? _____

Past Illnesses or Injuries: _____

Past Surgeries: _____

Current Medications: _____

_____

Current Eye Drops: _____

_____

Medicines that cause reactions or sensitivities: _____

Specific Allergies: _____

Name: _____

Interview - Comprehensive

Eye Conditions: *Have you ever been diagnosed with any of the following conditions?*

Cataract:	No	Yes	If Yes,	left	right	both
Age-related Macular Degeneration:	No	Yes	If Yes,	left	right	both
Glaucoma:	No	Yes	If Yes,	left	right	both
Diabetes:	No	Yes	If Yes,	left	right	both
Diabetic Retinopathy:	No	Yes	If Yes,	left	right	both
Dry Eye:	No	Yes	If Yes,	left	right	both
Eye infection, inflammation, or allergy:	No	Yes	If Yes,	left	right	both
Floaters and/or flashes of light:	No	Yes	If Yes,	left	right	both
Iritis or Uveitis:	No	Yes	If Yes,	left	right	both
Retina defects or degenerations:	No	Yes	If Yes,	left	right	both

Eye Concerns: *Are you having any of the following eye concerns?*

Redness:	No	Yes	If Yes,	left	right	both
Burning:	No	Yes	If Yes,	left	right	both
Itching:	No	Yes	If Yes,	left	right	both
Tearing:	No	Yes	If Yes,	left	right	both
Discharge:	No	Yes	If Yes,	left	right	both

Vision Concerns: *Are you having any of the following vision concerns?*

Blurred Vision:	No	Yes	If Yes,	left	right	both
Eyestrain:	No	Yes	If Yes,	left	right	both
Eye Pain:	No	Yes	If Yes,	left	right	both
Severe sensitivity of lights:	No	Yes	If Yes,	left	right	both
Headache:	No	Yes	If Yes,	left	right	both
Poor night vision:	No	Yes	If Yes,	left	right	both
Bothersome night glare:	No	Yes	If Yes,	left	right	both
Double vision:	No	Yes	If Yes,	left	right	both
Total loss of vision:	No	Yes	If Yes,	left	right	both

Vision Correction:

What corrective lenses are you mainly using for far/distant vision activities?

No Correction Contact Lenses Eyeglasses

Describe the quality of your far/distant vision activities:

Acceptable Need more improvement Blurred

What corrective lenses are you mainly using for near/reading vision activities?

No Correction Contact Lenses Eyeglasses

Describe the quality of your near/reading vision activities:

Acceptable Need more improvement Blurred

What corrective lenses are you mainly using for computer vision activities?

No Correction Contact Lenses Eyeglasses

Describe the quality of your computer vision activities:

Acceptable Need more improvement Blurred

Computer Demands: *Do you have any of the following computer demands on your vision?*

Computer use for extended periods:	Yes	No
Unusual ergonomic demands:	Yes	No
Must simultaneously view paperwork and computer:	Yes	No
Use of laptop:	Yes	No
Use of multiple desktop monitors:	Yes	No

Hours of computer use, per day _____ hours

Performance & Outdoor

Vision Performance*: Do you have any of these vision performance problems?*

Poor reading skills or low reading performance:	Yes	No
Inconsistent sports vision performance:	Yes	No
Slowness when shifting focus:	Yes	No
Difficulty with 3-D images, movies or TV:	Yes	No

Outdoor Demands: Describe any special outdoor demands.

Extended night driving:	Yes	No
Outdoors in direct UV exposure:	Yes	No
Read in outdoor settings:	Yes	No
Irritated contact lenses when outdoors:	Yes	No

Retinal Health Screening Tests

Your annual eye exam at Piedmont Eyecare Associates includes an examination of the back of your eye. This examination is important in the early detection of disorders which may be harmful to your vision, including Glaucoma, Hypertension, Diabetes, and Macular Degeneration. We recommend two screening tests at your annual eye examination. These tests are not covered by insurance plans because they are preventive in nature, but we keep the cost as low as possible.

DIGITAL RETINAL PHOTOGRAPHY - Recommended for all patients annually **$36**

This technology combines retinal photography with computerized imaging to allow instant viewing of the retina and optic nerve in great detail. The benefits to Digital Retinal Photography are:

- Early diagnosis of abnormal conditions
- Maintain a digital record of the back of your eye
- No light sensitivity
- No stinging
- No drops

MACULAR PIGMENT DENSITY TEST - Recommended for patients age 30 and above **$25**

This measures your risk for developing macular degeneration, a leading cause of blindness in the United States.

We encourage you to take advantage of both tests for a combination value of $48

☐ **Combination Value $48**

☐ **Retinal Photography only $36**

☐ **Macular Pigment Density Test only $25**

☐ **I do not wish to have any screening tests**

DILATION:

Dilation involves opening your Pupils with drops so that the doctor can look at the back of your eye.
If you have the screening retinal photography above, it is generally adequate.
Dilation has the following side effects:

- Sensitivity to light
- Blurry vision
- Possible stinging
- Requires eye drops

I prefer to DECLINE Dilation* _____

If you are 65 or older and/or diabetic you will be dilated to meet insurance health requirements.

By signing, I also understand that Piedmont Eyecare Associates, O.D. is required by law to protect my privacy and health information, as stated in the *Notice of Privacy Practices*. A copy of this is available at the front desk.

Patient name (Print) _____

Patient/Guardian Signature _____ Date: _____

Please Read:
In order to control the cost of billing, we ask that the patient's portion is paid at the time services are rendered unless other arrangements are made in advance. We would rather control billing costs than be forced to raise our fees. All professional services and material are charged to the patient. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Accounts 90 days old are subject to collection fees. There will be a service charge on all returned checks.
Your signature will allow Piedmont EyeCare to file the insurance you provided for your exam today. Payment from my insurance is to be paid directly to Piedmont EyeCare. I understand that my insurance will be billed as my primary insurance. I understand that billing any secondary insurance is my responsibility. I understand that all benefits quote to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed.

_____ _____

Signature **Date**

Patient/Guardian Signature _____ Date: _____