EYE CLASS OPTOMETRY

APPT TIME: _____
ARRIVED: _____
TIME SEEN: _____
DX CODE: _____
PROC CODE: _____
_____
_____
PRAC ID: _____

WELCOME TO OUR OFFICE!!

Name: _____ Date of Birth: _____

Address: _____ Postal Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Alberta Health Care Number: _____

Do you have Vision Insurance? ☐ Yes ☐ No If yes name of Insurance → _____

Date of last eye exam: _____ Previous Eye Doctor: _____

How did you hear about our office? _____

Please check any of the following reasons for this exam:

☐ Routine Eye Health Examination ☐ New Glasses ☐ Reading Glasses ☐ Contact Lenses

Personal Ocular History: Do you have any of the following? If yes, please check all applicable boxes.

☐ Blurry Vision ☐ Dry Eyes ☐ Itchy Eyes ☐ Eye Discomfort ☐ Eye Pain ☐ Flashes of light ☐ Floaters
☐ Double Vision ☐ Light Sensitivity ☐ Eye Injuries ☐ Other: _____
☐ Eye Surgeries (What type and when?): _____
If you checked any of the above, please explain: _____

Do you have a family history of any of the following? If yes, please check the applicable box and state relationship.

☐ Macular Degeneration ☐ Glaucoma ☐ Retinal Detachment ☐ Cataracts ☐ Other: _____

Personal Medical History: Please check all applicable boxes.

☐ High Blood Pressure ☐ High Cholesterol ☐ Diabetes ☐ Cardiovascular Problems ☐ Blood/Lymphatic Problems
☐ Headache ☐ Allergic/Immunologic Problems ☐ Respiratory Problems ☐ Other: _____
☐ Surgeries (What type and when?): _____
☐ Are you pregnant, plan to become pregnant or currently breast-feeding? ☐ Yes ☐ No ☐ Not Applicable

Would you say that you are in good health? ☐ Yes ☐ No If No, please explain: _____
Do you have any allergies to medications? ☐ Yes ☐ No If Yes, please explain: _____

Are you currently taking any medications?

☐ Yes ☐ No If Yes, please list all medications and dosage: _____

Name of family physician: _____

Please check Yes or No

Do you smoke? ☐ No ☐ Yes If yes, how often _____
Do you drink? ☐ No ☐ Yes If yes, how often _____

I understand that if my insurance eligibility cannot be verified or if my insurance does not re-imburse the amount charged to my account, that I will be financially responsible for payment of all charges incurred for services received from Eye Class Vision Care, Inc.
Privacy Notice: This office's privacy practices are in accord with PIPA regulations. A copy is provided anytime when requested. Your signature indicates that you have been advised of this information.

Signature _____ Date _____

EXPLANATION OF EXAMINATION FEE SCHEDULE – ALBERTA HEALTH CARE VS. PRIVATE PAY

(Please check all of the following that may apply to your visit)

COMPREHENSIVE VISION & EYE HEALTH EXAMINATION

____ **Children (ages 0-18):** Exam fees are covered by Alberta Health and Wellness
Have you seen an Optometrist since July of last year? □ Yes □ No
(If you say no, and your claim is denied because you have already seen another Optometrist you will personally be billed directly for this exam).

____ **Seniors (65+):** Exam fees are covered by Alberta Health and Wellness
Have you seen an Optometrist since July of last year? □ Yes □ No
(If you say no, and your claim is denied because you have already seen another Optometrist you will personally be billed directly for this exam).

____ **Adults (ages 19-64):** $119. This fee can be re-imbursed through your Vision Insurance
____ Dilation fee $30. The doctor will advise you if this procedure is required.

MEDICALLY NECESSARY EYE HEALTH CARE (AVAILABLE TO PATIENTS OF ALL AGES)

____ All medically necessary exams and required follow-ups to address acute care issues are billable to Alberta Health Care for all patients but does NOT cover the determination of your prescription for glasses or contact lenses.

CORNEAL HEALTH AND CONTACT LENS FITTING FEES

- Contact lenses are medical devices which can cause serious and permanent damage including vision loss if they are not fit and used properly. The appropriate contact lens fitting fee will be determined by the Doctor after he/she has determined which contact lens type is best for your needs.
- Our comprehensive corneal health and contact lens fitting fee includes the following:
  - Corneal topography health analysis, all required contact lens trial lenses during the fitting process, sample contact lens solutions and all follow-up contact lens visits to ensure clear, comfortable, healthy and sustainable contact lens wear.

___ Single Vision Soft Contact Lenses (no astigmatism)	$40
___ Toric Soft Contact Lenses (to correct astigmatism):	$70
___ Multi-focal Soft Contact Lenses (with a reading prescription)	$100
___ Complex Soft of Gas Permeable Contact Lenses	$100

DILATION CONSENT

Dilating eye drops are used to enlarge the pupils of the eye to allow the doctor to get a better view of the inside of your eye. The eye drops are necessary to diagnose certain ocular conditions but may blur your vision for a length of time which varies from person to person and may make bright lights bothersome. Since driving may be difficult immediately following your exam it is best to make arrangements not to drive yourself. Adverse reactions such as acute angle-closure glaucoma can be triggered by the dilating drop but this is rare and treatable with immediate medical attention. Other side effects such as light sensitivity and difficulty reading may persist for a few hours.

_____ **(Yes)** I hereby **CONSENT** to dilation by Eye Class Optometry and any of it's staff to administer dilating eye drops at any of my visits as required by my eye condition.

_____ **(No)** I hereby **DECLINE** dilation by Eye Class Optometry and any of its staff despite understanding it's importance.

I have read and consent to the above fees, terms and conditions.

_____ _____

Signature of responsible party (must be 18 or older) Date

For children <18 years old, guardian must sign for patient