A complete retinal evaluation is an essential part of a comprehensive eye exam and the standard of care. As part of their ongoing commitment to your eye health, the Doctors at Oregon Trail Eye Care include the Optomap Retinal Exam as part of your yearly comprehensive eye examination. This advanced screening technology is the Doctors' preferred way of obtaining a detailed view of your retina **without having to *dilate* your eyes.*** The ultra wide-field digital image is used for early detection and management of eye diseases, as well as systemic diseases. The digital image will become a permanent part of your medical record and will be compared from year to year to detect any changes. The Optomap Retinal Exam is fast, easy, and comfortable.

I understand that there is an additional $35 charge for this test and that it is not covered by most insurance plans.

Patient Signature _____ **Date** _____/_____/_____

*Dilation may still be necessary in some circumstances.

* Oregon Trail Eye Care Contact Lens Evaluation Fees *

Spherical	Toric (Astigmatism)	Multifocal	Multifocal Toric	RGP	RGP Multifocal	Scleral
$60	$70	$80	$85	$100	$110	$200

PLEASE CHECK ONE

- ☐ I would like to update my contact lens prescription today
- ☐ I would like to try contact lenses
- ☐ I am not interested in contact lenses

Please Read: **Consent to Treat and HIPAA Compliance**

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.

Payment from my insurance is to be paid directly to Oregon Trail Eye Care, PC. I understand that any services rendered will be billed to my primary insurance. I understand that billing any secondary insurance is my responsibility. I understand that all benefits quoted 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.

Most of us feel that our health information is private and should be protected. There is a federal law called the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which gives you rights over your health information, including the right to get a copy of your information, make sure it's correct, and know who has seen it.

I acknowledge that I have received or will receive a copy of my contact lens and/or glasses prescription at the completion of my exam.

Guardian / Patient Signature_____**Date**_____/_____/_____

****If patient is under the age of 18 a Guardian MUST sign****

OREGON TRAIL EYE CARE, PC

Dr. Jeff Collins, O.D.

PATIENT INFORMATION

Legal Name_____

Preferred Name_____

Date of Birth_____ Cell Phone_____

Mailing Address_____

City_____ State_____ Zip_____

Height_____'_____" Weight_____ SSN_____

RESPONSIBLE PARTY

Name_____

Date of Birth_____

Cell Phone_____

← ← ← **Please provide an email !!!**

Email_____

Date of Last Exam **(If not with us):**_____ Currently Wear Glasses? **Y N**

Place of Last Exam **(If not with us):**_____ Currently Wear Contacts? **Y N**

Are you experiencing any of the following?
WITH CORRECTION (If applicable)

- ☐ Blurry Vision ***near*** *or* ***distance***
- ☐ Dryness
- ☐ Light Sensativity
- ☐ Eye Strain
- ☐ Neck Pain
- ☐ Headaches/Migraines
- ☐ Motion Sickness
- ☐ Discomfort at a Computer
- ☐ Double Vision
- ☐ Floaters/Spots
- ☐ Light Flashes/Halos
- ☐ _____

Ocular History / Surgery

- ☐ Cataracts
- ☐ Strabismus
- ☐ LASIK or PRK
- ☐ Macular Degeneration
- ☐ Glaucoma
- ☐ Retinal Detachment or Tear
- ☐ Keratoconus

FAMILY Ocular History
***M** Mother, **F** Father, **S** Sibling, **G** Grandparent*

- ☐ Glaucoma **M F S G**
- ☐ Retinal Detachment or Tear **M F S G**
- ☐ Cataracts **M F S G**
- ☐ Strabismus **M F S G**
- ☐ Macular Degeneration **M F S G**

FAMILY Medical History

- ☐ Diabetes **M F S G**
- ☐ High Blood Pressure **M F S G**
- ☐ High Cholesterol **M F S G**
- ☐ Thyroid **M F S G**
- ☐ Cardiovascular **M F S G**
- ☐ Cancer **M F S G**

Medical History

- ☐ Diabetes ***Type 1*** ***Type 2***
  - HbA1c_____% Blood Sugar_____

Diabetic Doctor:_____

- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Thyroid ***Hyper*** ***Hypo***
- ☐ Cardiovascular
- ☐ Cancer
- ☐ Arthritis
- ☐ Gastrointestinal Condition
- ☐ Psychiatric Condition
- ☐ Neurological Condition
- ☐ Sleep Apnea
- ☐ _____

Current Medications

_____

_____

_____

_____

Allergies to Drugs/Medications

- ☐ None
- ☐ _____

ARE YOU? :

- ☐ Pregnant
- ☐ Nursing
- ☐ N/A

Do You Currently Smoke? *Y N*

Former Smoker? *Y N*

Do You Drink Alcohol? *Y N*

Recreational Drug Use? *Y N*

Primary Care Doctor_____

Preferred Pharmacy_____