Welcome to Cary Optometric, PA

PATIENT INFORMATION

Patient's Last Name:	First:	MI:	Nickname:
Home Address:			City, ST Zip:
Phone: (check preferred) ❑ Hm:	❑ Cell:		❑ Wk:
Email Address:	DOB:	Sex: ❑ M ❑ F	Marital Status: ❑ Single ❑ Married ❑ Other
SS#:	Employer/School:	Occupation/Grade:	
Billing Address (if different):			
Why did you choose our office? ❑ Website ❑ Location ❑ Ins. Plan ❑ Other ❑ Referred by:			
Parents/guardians if patient is a minor	Other family members seen at this office:		
Primary Physician:	Practice Name and Phone:		
Previous Eye Doctor:	Address and/or phone (if CL RX or records of a medical condition are needed)		
Race: ❑ Asian ❑ Black/African American ❑ Pacific Islander ❑ Native American/Alaskan ❑ White ❑ Decline			
Ethnicity: ❑ Not Hispanic or Latino ❑ Hispanic or Latino ❑ Decline	Preferred Language: ❑ English ❑ Spanish		

INSURANCE INFORMATION

Please note: Most "Vision" plans only cover refractions and routine, non-medical eye exams. Visits involving medical problems such as conjunctivitis, dry eye, ocular injuries, cataracts, glaucoma, macular degeneration, sudden pain or vision loss or monitoring for ocular side effects of chronic diseases such as diabetes and hypertension fall under your medical insurance coverage, not your "vision" plan. Some Well Vision Plans will apply your benefits toward medical co-pay and deductibles and some do not. If you have any questions about your coverage, be sure to contact your insurance company before your scheduled appointment.

Medical Insurance Carrier:	ID#	Policy/Group #	
If the patient is NOT the insured, please fill out the following information for the INSURED:			
Name:	DOB:	SS #:	Patient's relation to insured: ❑ Spouse ❑ Child ❑ Other
Address (if different):		Phone:	
Vision Plan:	ID#:	Policy/Group #:	
If the patient is NOT the insured, please fill out the following information for the INSURED:			
Name:	DOB:	SS #:	Patient's relation to the insured: ❑ Spouse ❑ Child ❑ Other
Address (if different):		Phone:	

Marcia Dettloff, OD

160 NE Maynard Rd, Ste 110 • Cary, NC 27513 • (919) 481-4682 • Fx (919) 415-0422 • caryopto.com

Cary Optometric Financial Responsibilities and Consent

Patient Name: _____ DOB: _____

Financial Responsibilities

- You (or your legal guardian) are responsible for the payment of your account including payment of co-pays, coinsurance, deductibles, all other procedures or treatment not covered by his/her insurance plan and all direct or indirect fees incurred in collecting any outstanding balance.
- While we will assist in filing for insurance, we cannot guarantee coverage. As the insured, you are responsible for knowing your insurance benefits and requirements for coverage and ensuring that any necessary referrals or authorizations are obtained before receiving services. In the event of a dispute or rejection of a claim you are responsible for payment.
- We may file some types of insurance for you as a courtesy however; you are responsible for staying in contact with the insurance company to assure that they pay in a timely matter. We may require payment for your services in full if your insurance company has not paid the benefits to us within 90 days of submission. Any insurance benefits that are later received for those services will be refunded to you. Payment is due at the time of the service. We accept cash, check, debit, Visa, MasterCard, and Discover.
- Bring your insurance card and picture ID to each visit.
- Notify our office of any changes in your address, phone or insurance.
- There will be a $25.00 fee plus our bank's fee for a returned check.
- A finance charge of 1 1/2% per month will be charged for any balance over 30 days past due.

Canceled Appointments

While we understand that there may be times when you miss an appointment due to emergencies or obligations, we ask that you give us 24 hour notice on all cancelled appointments. If you repeatedly miss appointments without any notification you will only be seen on a walk-in, space available basis or will be required to pay for your appointment in advance and payment will be forfeited if you do not show. Insurance does not cover missed appointments.

Records Release

We will provide a report of your most recent exam results and current spectacle and contact lens prescriptions at no charge. If you request copies of your full medical records, there will be a charge of $.25 per page and we may impose a minimum handling fee (including copies) of $10 plus the cost of any delivery method that you choose (or the fee allowed by the State of NC at the time of the request). All charges must be paid before the records will be released.

Acknowledgements:

I have read, understand and agree to the policies outlined above.

- I consent to the performing of optometric procedures agreed to be necessary or advisable.
- I authorize the release of any information contained in my records for the purpose of my treatment, billing and processing of insurance claims and I authorize payment of benefits to Cary Optometric, PA.
- The duration of this document is indefinite and continues until revoked in writing.

_____ _____

Signature Date

_____

Print Name (and relation if parent/guardian)

Notice of Privacy Practices:

I acknowledge that a copy of the Cary Optometric Notice of Privacy Practices has been made available to me.

_____ _____

Signature Date

Marcia Dettloff, OD

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General Medical History

Primary Physician	Physician's Phone number	When was your last physical exam?

Check the box for any conditions that apply:

	You	Mom	Dad	Sib	Describe
Diabetes	☐	☐	☐	☐	Type:
Hypertension	☐	☐	☐	☐	
Thyroid disease	☐	☐	☐	☐	
Cardiovascular disease	☐	☐	☐	☐	
Cancer	☐	☐	☐	☐	

If ***YOU*** are diabetic, what year were you diagnosed?	What was your last A1c level?

Check if applicable: ☐ I am pregnant ☐ I am nursing	Do you live alone? ☐ Yes ☐ No ☐ Assisted Living ☐ Nursing Home

Smoking history: ☐ Never ☐ Former smoker ☐ Some days ☐ Every day	Alcohol use: ☐ None ☐ Occasional ☐Social ☐ 1drink/day ☐ 2+drinks/day

List ALL major injuries or surgeries you have had and approx dates:

List any other medical conditions you have, including non-drug allergies:

List all Rx and over-the-counter medications you currently take:

List any vitamins or supplements you currently take:

List any drug allergies you have

Review of Systems- list any problems you are currently having anywhere, from head to toe:

General (e.g., fever, fatigue, loss of appetite, unexplained weight loss/gain)

Ear, Nose, Throat (e.g., sinus/nasal congestion, nose bleeds, dry mouth/throat, sleep apnea, hearing problems)

Cardiovascular (e.g., chest pain, racing heartbeat, swollen feet/ankles, TIAs)

Respiratory (e.g., chronic cough, shortness of breath, wheezing)

Genital, Kidney, Bladder (e.g., bladder/urinary problems, pain, discharge, menstrual changes, impotence)

Gastrointestinal (e.g., constipation, diarrhea, gastric reflux (GERD), jaundice, nausea, vomiting)

Endocrine (e.g., heat or cold intolerance, thinning hair, excess thirst, excess urination)

Muscles, Bones, Joints (e.g., pain, stiffness, swelling, weakness, limited movements)

Skin (e.g., dry, itchy, flaky, rash, growths, bumps, redness, discoloration)

Neurological (e.g., headaches, numbness/tingling, tremors, poor balance, dementia, speech problems)

Psychiatric (e.g., depression, anxiety, sleep problems, paranoia, obsessive/compulsive)

Blood/Lymph (e.g., anemia, bleeding gums, delayed clotting, unexplained bruising)

Allergy/Immune (e.g., swollen lymph nodes, itching, sneezing, runny nose/eyes)

Ocular History

Who was your previous eye doctor?	When was your last eye exam?

Check any conditions that apply:

	You	Mom	Dad	Sib	Describe
Glaucoma	☐	☐	☐	☐	
Macular Degeneration	☐	☐	☐	☐	
Retinal problems	☐	☐	☐	☐	
Cataracts	☐	☐	☐	☐	
Lazy eye/Eye turn	☐	☐	☐	☐	

List major EYE injuries, infections or surgeries and approx dates

List any other eye problems you have had in the past

List any EYE drops you use (Rx or OTC)

List any vision complaints you are having such as:

- blurred vision, headaches, eyestrain, double vision or losing your place when reading;
- itching, burning, redness, sensitivity to light, watering, crusting or mucus discharge;
- seeing dark spots, squiggles or webs, bright flashes or colored rainbows around lights at night.

How many hours/day do you typically spend using a computer or other digital devices?

If you're having complaints with computer work, how far is the monitor from your eyes?

How many hours/day do you typically spend reading books, magazines, etc?

What are your hobbies?

Do you have sunglasses?	Do you have back-up glasses?	Are you are interested in contacts lenses?
What are your goals for contacts lens wear?		Have you had problems with contacts in the past?

Contact Lens Wearers Only

What disinfecting solution do you use?

How long do you wear your contact lenses?

How often do you replace your contact lenses?	When you replace them, are the new lenses noticeably clearer or more comfortable?

How old is your current pair of contacts lenses?

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