

# Wood Eye Care Centers

\*This form must be completed in full at every visit.\*

## PATIENT INFORMATION

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Email: \_\_\_\_\_@\_\_\_\_\_

SSN: \_\_\_\_-\_\_\_\_-\_\_\_\_ (must have at least last 4 numbers for insurance claims) Sex: \_\_Female \_\_Male

Home Phone: (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_

Communication Preference: \_\_\_Telephone \_\_\_Text \_\_\_Email \_\_\_Postal

Please list below individuals with whom we can communicate with about your medical history:

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone \_\_\_\_\_

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## INSURANCE INFORMATION

### *Vision Insurance*

Name of Insurance: \_\_\_\_\_

Member ID: \_\_\_\_\_

Insured's Name: \_\_\_\_\_

Insured's DOB: \_\_\_\_\_

SSN of Insured: \_\_\_\_\_

### *Medical Insurance*

Name of Insurance: \_\_\_\_\_

Member ID: \_\_\_\_\_

Insured's Name: \_\_\_\_\_

Insured's DOB: \_\_\_\_\_

SSN of Insured: \_\_\_\_\_

Note: Most insurance policies pay only a portion of your total charges. If you have any questions about your coverage, please contact your representative. We do not guarantee the accuracy of benefit information given to us by insurance companies. Please understand that financial responsibility for your account is yours, not the responsibility of your insurance company. I authorize the release of any medical or other information necessary to process insurance claims. I authorize payment of medical or vision benefits either to the physician or supplier of services rendered or to myself if the provider does not accept assignment. I understand that I am responsible for any balance my insurance does not pay.

**MEDICAL INFORMATION:**

**Vision Information:**

Do you wear: \_\_\_Glasses \_\_\_Contacts If yes to contacts, additional fee applies for contact lens evaluation. First time contact lens wearers must have insertion & removal training \$45.

Are you having any vision problems today? (i.e. blurred vision, itchy, soreness, etc.) \_\_\_NO \_\_\_YES  
(if yes, please describe)

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Have you ever had any eye disease, eye infection, surgery, or injury? \_\_\_NO \_\_\_YES  
(if yes, please describe)

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**Social History:**

Are you a smoker: \_\_\_YES \_\_\_NO \_\_\_USED TO BE  
Do you regularly drink alcohol: \_\_\_YES \_\_\_NO

**Family Ocular History:** (if yes put who in your family has had this disease)

Macular Degeneration NO YES Whom: \_\_\_\_\_  
Glaucoma NO YES Whom: \_\_\_\_\_  
Cataracts NO YES Whom: \_\_\_\_\_  
Other: \_\_\_\_\_

**Personal Medical History:**

Do you have any problems in the following areas? If yes, please explain:

Cardiovascular NO YES \_\_\_\_\_ Lymphatic NO YES \_\_\_\_\_  
Endocrine NO YES \_\_\_\_\_ Muscular/Skeleton NO YES \_\_\_\_\_  
Gastrointestinal NO YES \_\_\_\_\_ Neurological NO YES \_\_\_\_\_  
Genitourinary NO YES \_\_\_\_\_ Psychiatric NO YES \_\_\_\_\_  
Head NO YES \_\_\_\_\_ Respiratory NO YES \_\_\_\_\_  
Immunology NO YES \_\_\_\_\_ Skin NO YES \_\_\_\_\_

Please list any other diagnoses that you may have:

\_\_\_\_\_

Are you currently taking or do you have any allergies to medications? \_\_\_YES \_\_\_NO  
If yes please list below.

Current Medications	Allergies: Medication and reaction

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Wood Eyecare Centers

woodeyecare.com

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Ph) 770-978-2990  
F) 770-978-2993

**Dr. James Wood Dr. Susan Wood**  
**Dr. Lay Nim**  
*Doctors of Optometry*

2100 Riverside Parkway  
Suite 108  
Lawrenceville, GA 30043  
Ph) 770-237-8820  
F) 770-237-0944

We pride ourselves on providing our patients with the best possible standard of care. **Because of this, we now perform the optomap® Retinal Exam on all of our patients.** The Optomap allows our doctors to capture an image of the back of your eye where potential vision threatening diseases can be found. This includes **diabetes, glaucoma, certain types of cancer, retinal tears, and cardiovascular issues.**

**Also, you will not need to be dilated after the Optomap is captured.**

When reviewed, the scan becomes a permanent part of your medical file, enabling the doctor to make important comparisons should potential vision threatening conditions show themselves at a future examination. **The Doctor prescribes the Optomap Retinal Exam once per year for all patients.**

As part of your pre-test work up, we will capture optomap® images for review with the doctors during your examination today. **There is a \$39 co-pay for the Optomap with your vision insurance.** Any questions you have about the optomap® Retinal Exam can be directed to doctor when they review the images with you during your exam.

I have read and understand this document:

Sign: \_\_\_\_\_ Date: \_\_\_\_\_

