Eye Care of Virginia

Dr. Miles W Press

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(first) (mi) (last)

Patient _____ Birthdate ____-____-____ Sex ___ Age ____

Responsible person (if patient is a minor)_____ Birthdate ____-____-____

Address_____City_____State_____Zip Code_____

Mailing address if different_____City_____State____Zip Code_____

Home Telephone# _____ Cell phone# _____ Work# _____

Employer_____Occupation_____

Email_____ Vision Insurance_____ Policy or ID#_____

Health Insurance (Major Medical)_____ Policy#_____

Have you seen Dr. Press before? _____ How did you hear about us? _____

When was your last eye exam? _____ When was your last physical exam? _____

REASON FOR YOUR VISIT TODAY (CHECK (√) ALL THAT APPLY)

□-General Eye Exam □-Need new glasses □-Contact Lens Exam □-See Spots, Flashes, or Floaters □-Eyes itch, water or burn

□-Headaches □-Pink Eye □-Blurred Vision Distance/Near □-Other (Explain) _____

CONTACT LENSE INFORMATION

Do you wear contacts □-Yes □-No If so, what type: □-Soft □-Gas Perm/Hard □-Disposable □-Astigmatic □-Custom

How many years have you worn contacts? ___ How do you wear them? □-Daily □-Extended wear- What brand? _____

Are you interested in wearing them if you don't already? □-YES □-NO

Are you interested in being evaluated for laser vision correction? _____

GENERAL MEDICAL/EYE HEALTH HISTORY

Your health, medications & family history can play an important role in your eye examination. Please answer ALL questions completely if it applies to you.

List your medications currently taking_____

_____

Are you allergic to any medications? If so, what?_____

Current smoker? ____ Former smoker? _____ If applicable, are you pregnant?_____

Do you or any of your relatives suffer from or have a history of any of the following? (√) all that applies.

	Self	Family History
High Blood Pressure		
Cancer		
HIV Positive		
Glaucoma		
Retinal Detachment		
Dry Eyes		
Diabetes		
Arthritis		
Asthma		
Cataracts		
Eye Surgery		
Thyroid Disorder		
Heart Disease		
Seasonal allergies		
High Cholesterol		
Lazy Eye/ Amblyopia		
Unknown Blindness		
Macular Degeneration		

PAYMENT IS EXPECTED AT TIME SERVICES ARE RENDERED

Eye Exam **$79.00** (written Rx for glasses if needed)

Contact Lens Exam/Fitting Fee **$140.00** (written Rx for glasses/contacts & **1** pair of contacts)

Once services are rendered, they are FINAL. This includes contact lens fitting fees.

I clearly understand that it is **my responsibility** to know if I have vision insurance coverage **AT THE TIME** of my exam. I authorize the use of this form on all of my insurance submissions. I authorize release of information to all my insurance companies. I authorize payment directly to my doctor. I permit a copy of this authorization to be used in place of the original. I understand I am responsible for my complete bill and balance due (even if for **ANY** reason insurance does not pay). If insurance coverage cannot be verified on day of service, I will be responsible for submitting my own claims. No information about my case will be released to or discussed with an outside party without my written request authorizing the release.

This office is independently owned by Dr. Press and has no financial relationship with Walmart or their Vision Center*

***Patient Signature** (parent if under the age of 18)*_____