



**BARTLETT, GRIGSBY, BOAN, AND ASSOCIATES, O.D., P.L.L.C.**

**STATESVILLE • SALISBURY • HICKORY**

**Welcome to Our Office!**

We want to provide you with the very best in vision care. We realize that your time is valuable and will try to attend to you as quickly as possible. In order for us to serve you better, please provide us with the following information for our records. Of course, all information you provide will be held in strict confidence (please see our "Notice of Privacy Policies" for more details.)

**Personal Information**

Name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (Middle) \_\_\_\_\_

Preferred Name: \_\_\_\_\_ Title: Mr. Mrs. Miss Dr. Rev. Other: \_\_\_\_\_

Address: (street) \_\_\_\_\_  
(city, state, zip) \_\_\_\_\_

Telephone: (home) \_\_\_\_ - \_\_\_\_ - \_\_\_\_\_ (work) \_\_\_\_ - \_\_\_\_ - \_\_\_\_\_ x \_\_\_\_

Employer: \_\_\_\_\_ Social Security # \_\_\_\_/\_\_\_\_/\_\_\_\_

E-mail Address: \_\_\_\_\_  
(may we send you information via e-mail? Y N )

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: M F

Referred by: \_\_\_\_\_ Friend (name: \_\_\_\_\_)  
\_\_\_\_ Insurance  
\_\_\_\_ Employer  
\_\_\_\_ Yellow Pages  
\_\_\_\_ Internet  
\_\_\_\_ Other: \_\_\_\_\_

**Ocular Information**

Approx. Date of Last Eye Exam: \_\_\_\_\_ By whom? \_\_\_\_\_

Have you ever worn: \_\_\_ Eyeglasses \_\_\_ Contact lenses

Do you currently wear: \_\_\_ Eyeglasses \_\_\_ Contact lenses

Are you interested in (check all that apply):

\_\_\_ Refractive Surgery (LASIK) \_\_\_ No dilation examination (Optos)

\_\_\_ First time contact lenses \_\_\_ 30 day continuous wear contacts

\_\_\_ Bifocal contact lenses \_\_\_ Changing your eye color

Do you take any medications for your eyes? Y N

What: \_\_\_\_\_

Do you have(or have you had) any of the following? (check all that apply):

\_\_\_ Headaches \_\_\_ Double vision \_\_\_ Eye turn  
\_\_\_ Eye surgery \_\_\_ Eye injury \_\_\_ Redness  
\_\_\_ Itching \_\_\_ Burning \_\_\_ Gritty/sandy feeling  
\_\_\_ Eye pain \_\_\_ Floaters \_\_\_ Flashing light  
\_\_\_ Glare \_\_\_ Blurry vision \_\_\_ Distorted vision  
\_\_\_ Eyelid problems \_\_\_ "lumps/bumps" on eyes or eyelids

Eye History: Have you been diagnosed with any of the following?

\_\_\_ Eye Turn/ Lazy Eye \_\_\_ Glaucoma \_\_\_ Cataracts  
\_\_\_ Eye degeneration \_\_\_ Eye Injury \_\_\_ Eye Surgery

Personal Medical Information

Primary care physician: \_\_\_\_\_ Last physical: (mo/yr) \_\_\_\_\_

List medications you are taking: \_\_\_\_\_

List medication allergies (if any): \_\_\_\_\_

Review of systems (patient only)- Do you have problems with any of the following? (check any that apply):

- \_\_\_ Nervous system \_\_\_ Bones/Joints \_\_\_ Ear/Nose/Throat
\_\_\_ Skin \_\_\_ Genitourinary \_\_\_ Blood/circulation (incl. Hypertension)
\_\_\_ Respiratory \_\_\_ Cardiovascular \_\_\_ Mental/Psychological
\_\_\_ Endocrine (incl. Diabetes)

Has anyone in your immediate family had any of the following? (Check all that apply)

- \_\_\_ Diabetes \_\_\_ Hypertension \_\_\_ Thyroid disease \_\_\_ Cancer
\_\_\_ Glaucoma \_\_\_ Blindness \_\_\_ Macular Degeneration
\_\_\_ Other eye disease: \_\_\_\_\_

For what medical conditions have you been treated in the last two years?

- Do you use tobacco products? \_\_\_ No \_\_\_ Yes ( \_\_\_ daily \_\_\_ often \_\_\_ occasionally)
Do you drink alcoholic beverages? \_\_\_ No \_\_\_ Yes ( \_\_\_ daily \_\_\_ often \_\_\_ occasionally)
Do you have any substance abuse problems? \_\_\_ No \_\_\_ Yes

Payment/Privacy Policy (all patients to read and sign)

Our policy is that payment be rendered at time of service for all professional services. A 50% down payment is required on all ophthalmic materials. Please visit our website at www.oechickory.com for our policies regarding returns and refunds.

We will file for assignment on most insurance. If we do not accept assignment on your insurance, you may pay us in full at the time of service and we will file the necessary paperwork (at no charge to you) for your insurance to reimburse you directly. Even if we agree to file for assignment on your insurance, your bill is still your responsibility. If we agree to accept assignment, we will make a good faith effort to collect from your insurance company. However, if your insurance will not pay us (for any reason), the bill is your responsibility. We make every effort to work with our patients on their bills, but delinquent accounts will be settled through the court system or collection agency. Please verify your benefits with your insurance company before coming for your appointment. Any estimate of your charges that we give you based on information your insurance company provides us is not binding if your insurer later reduces payment or denies the claim for any reason.

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our Notice before signing this consent (paper copy or online at www.oechickory.com). As provided in the Notice, the terms of the Notice may change. If we change our Notice, you may obtain a revised copy at our website, www.oechickory.com.

I have read and understand the above Payment Policy. I hereby acknowledge that I have read and/or received a copy of the Notice of Privacy Practices for Bartlett, Grigsby, Boan, & Associates, OD, PLLC (Optometric Eye Care Center).

Patient name (print): \_\_\_\_\_

Guardian name (print)(if patient under 18): \_\_\_\_\_

Signature (Guardian if under 18): \_\_\_\_\_

Date: \_\_\_/\_\_\_/\_\_\_\_\_



**AN IMPORTANT ANNOUNCEMENT FROM YOUR DOCTOR**

Optometric Eye Care Center is proud to provide our patients with the most highly advanced technology available in retinal screening today! Our ability to view your internal retinal health is now dramatically improved with the Optomap.

Doctor Boan is concerned about retinal problems such as macular degeneration, glaucoma, retinal holes or detachments and diabetic retinopathy (all of which can lead to partial loss of vision or blindness). Additionally, systemic diseases such as diabetes and high blood pressure can be detected during a retinal exam.

**EARLY DETECTION IS CRUCIAL!!**

**Optomap Provides:**

- An annual eye wellness scan
- An in depth view of the retinal layers (where disease can start).
- The ability to show you your images today during your exam.
- A permanent record for your medical file, which gives your doctor comparisons for tracking and diagnosing potential eye disease.

**Optomap:**

- Is fast, easy, and comfortable.
- Will *NOT* require dilating drops (which result in blurred vision and sensitivity to light).

Because your insurance is designed to cover only a basic eye exam, it does not cover advanced screening tools such as the Optomap. Dr. Boan would like for ALL of his patients to have an Optomap exam at their first visit and at recommended intervals thereafter. The additional fee is only \$29. Please check one of the following three options:

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I elect to have an Optomap of my retina.

**Patient Signature:** \_\_\_\_\_ **Date** \_\_\_\_\_

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I decline the Optomap exam. (If you decline the Optomap exam, you agree to dilation and agree that even a dilated view of the retina is not as accurate as the Optomap image and must sign below.)

**Patient Signature:** \_\_\_\_\_ **Date** \_\_\_\_\_

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I would like to discuss this procedure with the technician or the doctor and see a sample Optomap image.