Name: (Last) _____ (First) _____ (Middle) _____
Address: _____City_____State_____ Zip_____
Sex: M / F Age: _____ Date of Birth_____/_____/_____ Social Security#:_____/_____/_____
Home Phone: (_____) _____Day Time Phone: (_____) _____ Cell: (_____) _____
Employer: _____ Status: □ Not Employed □ Full-time □ Part-time □ Retired □ Student
Marital Status: □ Single □ Married □ Widowed □ Legally Separated □ Divorced
Race: □ White □ African American □ Asian □ Hispanic/Latino □ American Indian □ Native Hawaiian
Spouse/Emergency Contact: (Name) _____ Phone: (____) _____
Email:_____

Guarantor: (Person or entity financially responsible due to being under the age of 18 or legal responsibility)
Name:_____ Date of Birth:_____/_____/_____ Social Security#:_____/_____/_____

 # 1 MEDICAL Insurance (*Please provide Subscriber Information*):
Ins. Co. _____ ID #: _____ Birthday: ____/____/_____
Subscriber: _____ **Social Security #: _____/_____/_____
 # 2 MEDICAL Insurance (*Please provide Subscriber Information*):
Ins. Co. _____ ID #: _____ Birthday: ____/____/_____
Subscriber: _____ ** Social Security #: _____/_____/_____
VISION Insurance (*Please provide Subscriber Information*):
Ins. Co. _____ ID #: _____ Birthday: ____/____/_____
Subscriber: _____ **Social Security #: _____/_____/_____

Referred by: _____
Reason for today's visit: _____

Are you experiencing any of the following? (Check all that apply)

□ Blur at distance	□ Itching/Burning	□ Foreign body sensation	□ Redness
□ Blur when reading	□ Discharge/Tearing	□ Headaches	□ Ocular pain
□ Visual discomfort	□ Floaters/Spots	□ Light sensitivity	□ Injury
□ Dry eyes	□ Flashes of light	□ Other: _____	□ None

Have you had any of the following:

Diabetes? □Y □N Type? □1 □2 □Pre Blood Sugar: ____ Insulin Dependent? □Y □N Diagnosed ___/___/____
Glaucoma? □Y □N High Blood Pressure? □Y □N
Cataracts? □Y □N High Cholesterol? □Y □N
HIV Positive? □Y □N Blood Transfusion? □Y □N
Hepatitis? □Y □N Type _____ Other Medical Conditions ? _____
Eye Operation/Injury? □Y □N Type_____ Surgeon _____ Date____/____/_____
Are you pregnant? □Y □N How many weeks? _____
Do you wear glasses? □Y □N
Contacts? □Y □N Type_____ Wear time _____ Solution _____

Are you allergic to any medications? □ Y □ N (Please include all seasonal/other allergies)

_____

Do you use cigarettes/tobacco? □Y □ N How long? _____ How much? _____
Alcohol? □Y □ N Other Substances? □Y □ N

Does anyone in your family have:

Glaucoma?	**□ Y □ N**		**Relation** _____
Macular Degeneration?	**□ Y □ N**		**Relation** _____
Retinal Detachment?	**□ Y □ N**		**Relation** _____
Other eye conditions?	**□ Y □ N**	**What kind?**	**Relation** _____
Diabetes?	**□ Y □ N**		**Relation** _____
High blood pressure?	**□ Y □ N**		**Relation** _____

Name of family PCP doctor_____ **Date of last exam**_____/_____/_____

NOTICE OF PRIVACY POLICY & CONSENT

As described in our Notice of Privacy Practices, the use and disclosures of your health information for treatment purposes not only includes care and services provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional.
When you sign this consent document, you signify that you agree that we can and will use, and disclose your health information to treat you, to obtain payment for your services and to perform healthcare operations. You also signify that you have been offered a copy of our notice of Privacy Policies.

I authorize the office of **Ghent Eye Care** to release my personal health information, including financial records in accordance with HIPAA regulations specifically to the following individual only:

- _____
- _____
- _____
- _____

FINANCIAL AGREEMENT

If copayments and/or deductibles are designated by my insurance company, I agree to pay them at the time of service or upon receiving an invoice from Pegram and Cornetta PLC. I am aware that any contact lenses and/or eyeglasses materials orders are for my unique prescription and the fees for these purchases are **NOT** refundable once the order is in process.

DELINQUENT ACCOUNTS

In case of legal disputes, I understand I will have to absorb all legal fees, including court cost and attorney's fees. A $40.00 fee will be collected from the patient for any returned checks.

REFRACTIONS

Refraction is the measurement of the eyes for glasses and/or is done to determine a medical reason your eyesight is below normal. Most insurance plans, including **MEDICARE**, do not consider this to be a medical procedure, and therefore do not provide medical insurance coverage for this. If you choose to have refraction, you will be required to pay a fee of **$45.00** for **MEDICARE** patients **at the time services are rendered**, and/or full fees according to your insurance plan.

CONTACT LENS EXAMINATION

For your health and safety, we require annual contact lens evaluations. A separate fee **(Ranging from $90.00-$125.00)** is charged beyond the routine eye exam. We determine the fit, the health and condition of the eyes with contacts. We also evaluate changes in prescription and lens design during this process.

SIGNATURE ON FILE

I request that payment of authorized Medicare/Commercial benefits be made either to me or on my behalf to Dr. James V. Cornetta & Associates for any service furnished to me by that physician. I authorize release to the Centers for Medicare and Medicaid Services and its agents any medical information about me needed to determine the payments for related services.

_____	_____	_____/_____/_____
Print Name of Patient	***Signature of Patient***	***Date***

For Minors:

_____	_____	_____/_____/_____
Print Name of Guardian/Relationship	***Signature of Guardian/Relationship***	***Date***

Ghent Eye Care
OPTOMETRIST

Dr. George W. Pegram OD, Dr. James V. Cornetta OD, Dr. Amanda Martin OD

As part of a comprehensive eye examination, it is recommended that **ALL** patients have the internal health of their eyes thoroughly evaluated every year. This is performed as either a **dilated** retinal exam or the **Optomap** retinal imaging.

The retinal exam will allow your doctor to uncover and document 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) as well as systemic diseases such as diabetes and high blood pressure.
Just as your dentist regularly takes pictures of your teeth, or mammograms are used for early detection, your eyes deserve the same quality care.

Optomap retinal imaging will not require dilating drops which result in blurred vision and sensitivity to light for 3-4 hours.

- Provides an eye wellness scan.
- Allows your doctor to review your **Optomap** retinal image with you.
- Provides an annual, permanent record for your medical file.
- Is fast, easy and comfortable.

(Some patients may need to have their eyes dilated also)

Please choose **ONE** of the following health check options by marking the box next to your choice.**THERE IS AN ADDITIONAL CHARGE OF $39 FOR THE OPTOMAP RETINAL EXAM WHICH IS NOT COVERED BY INSURANCE.**

I have read and understand the above, and **agree** to:

☐ **($39) Optomap Retinal Exam**

☐ **Dilation** (covered under insurance)

HIPPA PRIVACY ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES
I understand that this office is HIPPA compliant and acknowledge that the HIPPA policies are available to read.

Patient/ Parent Signature: _____ Date:_____

Medication List

Name: _____

DOB: _____

Medication	Reason