



_____ has an appointment on: _____ at: _____
Name Date Time

- Your appointment is with:
- Dr. Paula Gorlin
 - Kristy Gleaton, L.D.O.

Location: **875 Lawrenceville Suwannee Road, Lawrenceville, GA 30043**
770-963-0370

About your appointment

Thank you for choosing us for your low vision exam. This appointment will allow us to determine if we can help you effectively use your remaining vision with the help of magnifying vision aids and other devices. Please understand that your loss of vision cannot be restored; however, we may be able to recommend some devices that will help with certain tasks. This paperwork has been sent or given to you so that you can fill it out at home. Please bring your completed paperwork, your insurance cards and any magnifiers you own.

Please bring all current eyeglasses and easily transportable low vision aids to your appointment.

Because our doctors often schedule up to an hour for each client, we ask that you let us know 24 hours before your appointment if you need to cancel or change your appointment time.



PLEASE PRINT

PATIENT		
Name: _____		
Address: _____ _____		
Phone: _____		
DOB: ____/____/____	<input type="checkbox"/> Single	<input type="checkbox"/> Male
Referred by: _____	<input type="checkbox"/> Married	<input type="checkbox"/> Female
SPOUSE OR LEGAL GUARDIAN		
Name: _____		DOB: ____/____/____

MEDICARE / INSURANCE INFORMATION

PATIENT / PRIMARY	SPOUSE / SECONDARY
_____ Insurance Co.	_____ Insurance Co.
_____ Insured's Name	_____ Insured's Name
_____ Relationship to Patient	_____ Relationship to Patient
_____ ID Number/Social Security	_____ ID Number/Social Security
_____ Group Number	_____ Group Number



HEALTH HISTORY

Patient Name: _____ Date: _____

Please check any of the following that apply to you now or in the past.

EARS/NOSE/THROAT

- Sinus problems
- Allergies
- Hearing loss

CARDIOVASCULAR

- Chest pain
- Heart attack
- Irregular heartbeats
- Pacemaker
- Heart murmur
- Open heart surgery
- Artificial heart valve
- Cardiac arrest
- High blood pressure

LUNGS

- Asthma
- Emphysema
- Shortness of breath
- Tuberculosis
- Chronic cough
- Lung surgery
- Lung cancer
- Oxygen use

DIGESTIVE

- Ulcer
- Intestinal problems
- Diarrhea
- Constipation

URINARY

- Chronic kidney infection
- Kidney stones
- Prostate problems
- Frequent urination
- Chronic bladder infection

LIVER

- Hepatitis
- Jaundice

Muscular/Skeletal

- Arthritis
- Joint pain
- Back problems
- Arm weakness
- Difficulty walking

NERVOUS SYSTEM

- Stroke
- Stroke affected vision
- Head injury
- Alzheimer's
- Confusion
- Dizziness
- Multiple sclerosis
- Field defect
- Depression

IMMUNE/ENDOCRINE

- Diabetes, # of years _____
- Thyroid (hypo/hyper)
- Hypoglycemia
- AIDS/AIDS related complex
- Lupus

SOCIAL

- Tobacco use (present/past)
- Alcohol abuse

Previous Surgical History:

LIST NAMES & DOSAGES OF ALL MEDICATIONS TAKEN REGULARLY:

MEDICATION ALLERGIES:

REVIEWED BY: _____



Patient Name: _____ Date: _____

As of January 1, 2010 the new fee structure is as follows:

FEE STRUCTURE

The low vision evaluation may consist of a refraction test as well as the low vision examination. The refraction test is used to determine your eyeglass prescription. If this has not been done by your current doctor in many years, the cost for the refraction test is \$65.00. Medicare allows the charge but does not pay for this charge. To minimize our billing costs we are asking you to pay the \$65.00 at the time of service. The examination fee is determined by the amount of time the doctor spends with the patient, typically one hour. Any vision aids prescribed during the evaluation typically are not covered by Medicare or private insurance plans.

Please bring all Insurance cards with you to the examination.

BY SIGNING BELOW, I HAVE READ AND UNDERSTAND IN THE EVENT THAT MY INSURANCE DOES NOT PAY ON THE CLAIM, I AM FINANCIALLY RESPONSIBLE FOR ALL OR ANY REMAINING COSTS.

PATIENT SIGNATURE

DATE