Denali Family Eye Care, LLC
1700 E Bogard Rd., A 101, Wasilla, AK 99654
(Phone) 907-745-2070 (Fax) 907-745-2079

Youth Patient Information

Exam Date: ____/___/_____
Patient Name: _____ Gender: M / F
Patient's Date of Birth: _____ Grade in School: _____
Parent/GuardianName(s):_____
Address: _____ City: _____ State: _____ Zip:_____
Parent/Guardian Cell Phone: _____ Parent/Guardian Home Phone: _____
Parent/GuardianEmail:_____
Preferred Method of Contact: ____Cell Phone ____ Home Phone ____Email
Is it OK to leave a message? ❑ Yes ❑ No
Is it OK to email your prescription to you upon your request? ❑ Yes ❑ No

Insurance Information

Does the patient have vision care benefits? ___Yes ___No
If yes, please provide company name and ID number: _____
Does the patient have medical health insurance ___Yes ___No
If yes, please provide company name and ID number:_____
Name of Person Responsible for Account: _____
Responsible Party's Date of Birth: ___/_____/_____
Responsible Party's Social Security Number: _____ Occupation: _____
Name of Employer: _____
Please list any family members of your household who come to our office.
_____

THANK YOU FOR COMING IN

How did you hear about our office?
____Insurance website ____Physician/Eye Doctor ____Website ____Facebook
____Passed by Office ____Friend/Family Member-Name_____

CORRECTIVE LENS HISTORY

Does the patient presently wear glasses? ___Yes ___No If yes, how old are the glasses? _____
When do they wear them?_____
Does the patient presently wear contact lenses? ___Yes ___No
What type? ___Soft Disposable ___Hard ___Gas Permeable ___Other
If yes, how old are the contacts? _____If no, have they ever worn contact lenses? ___Yes ___No

MEDICAL HISTORY

Please list any eye problems, medical problems, or learning/developmental problems this patient has:_____

_____

Is the patient currently having difficulties at school?_____

Patient's Primary Care Doctor? _____ Date of last exam/visit: _____

Please list current medications and/or supplements:

_____

Is the patient allergic to any medications? ___ Yes ___ No Please List:_____

_____

Previous Eye Doctor:_____ Last Eye Exam: _____

Have any bloodline relatives had glaucoma, macular degeneration, or other loss of sight? ___Yes ___ No

INFORMED CONSENT OR REFUSAL FOR A DILATED FUNDUS EXAM

To provide the most comprehensive exam possible we request that all our patients have a dilated eye exam. At least 60% of the retina cannot be viewed without dilation. The purpose is to enlarge the pupils to enhance the detection of any ocular diseases such as cataracts, glaucoma, retinal disease, malignant growth, and retinal detachment; all of which can lead to vision loss. In addition, some systemic conditions such as diabetes and hypertension can cause changes in the health of the eye and can be detected by dilation.

Possible side effects (**these side effects typically do not last longer than 4-6 hours**):

- Inability to focus at near
- Sensitivity to light
- Blurry distance vision for some patients
- Mild burning upon instillation
- Induced ocular hypertension: RARE cases have been reported in which redness and sharp pain is experienced because of increased eye pressure. If this happens, contact the doctor immediately.

Please Check One Box:

☐I understand the above and consent to have dilation done.

☐ I understand the above and decline dilation, at this time. I understand that potential for partial or total loss of vision may exist and, without dilation, may go undetected.

Signature:_____ Date:_____

****Please note that you are welcome to schedule an appointment, at a later date, for dilation if today does not work for you.**

Our goal is to provide the absolute best and the most complete care available. To provide this service in the most efficient manner, please be aware of the following office policies.

Please read and sign below:

- I acknowledge that I understand the Notice of Privacy Practices for the office of Denali Family Eye Care. (Copy available upon request)
- I authorize the release of any medical information necessary to process my insurance claims and/or for use in recommended professional referrals.
- I authorize payments of insurance benefits directly to Denali Family Eye Care for services received in this office.
- I understand that insurance coverage is not a guarantee of payment.
- I understand that I am financially responsible for all fees incurred for services rendered, which are not paid by my insurance and must be paid at the time of service.

Exam, Frame and Lens Policy

- There are no refunds on Frame, Lenses, or Exam services. There is no exchange on frame or lenses either. The frame and lenses you choose are the ones that are made specifically for your needs and prescription and are therefore non-refundable and no exchanges.
- All frames have a **1-year** manufacturer defect warranty. This does not include glasses that are lost or stolen.
- All lenses are eligible for changes if need be. This would include a RX change, non-adapt to progressive lenses, upgrades to other lenses, etc. This is only allowed within **30 days** of receiving your frame and lens order. There is a fee for upgrading lenses and will be determined based on the difference between lenses that were first ordered and the upgraded lenses. This is also subject to **30 days** from receiving your frame and lens order.
- Contact lens and Frame orders take 2-3 weeks as an estimated return time. Our optical lab is focused on high quality orders and will not rush orders. Instead, they ensure the quality is up to your standards.

Parent or Guardian Signature:_____