Patient Information

Date ___________________

Last Name_______________________ First Name ______________________Age ______ Date of Birth ____/_____/_____

Address ______________________________City_______________________State ______ Zip______________________

Parent/Guardian Name (if under age 18) ____

Telephone: Home_________________ Cell_____________________Email_____________________________________

We will use the phone numbers provided to call patients with reminders for appointments. The call may be live or pre-recorded.

Employer_______________________________________ Occupation____

Date of Last Eye Exam_________________________ From Dr. ____

What type of exam are you interested in? _______ Glasses _____ Contact Lenses _____ Medical Office Visit

Have you ever worn either of the following? ______ Glasses _____ Contact Lenses _____ Neither

What is the reason for your visit? ____

For medical and visual problems please explain location, frequency, and degree of discomfort _________________________

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Date of last medical exam with your primary care physician____

Visual and Medical History

Do you have any of the following?

Self				**Family**
Diabetes	Yes	No	How long_________	Yes No
Hypertension	Yes	No	How long_________	Yes No
Heart or Blood Problems	Yes	No	How long_________	Yes No
Thyroid Problems	Yes	No	How long_________	Yes No
Other Systemic Diseases	Yes	No	How long_________	Yes No
Glaucoma	Yes	No	How long_________	Yes No
Cataracts	Yes	No	How long_________	Yes No
Retinal Problems	Yes	No	How long_________	Yes No
Macular Degeneration	Yes	No	How long_________	Yes No
Headaches	Yes	No	How long________	
Eye Infections/ Injury	Yes	No	How Long________	
Double Vision	Yes	No	How Long________	
Dry Eyes	Yes	No	How Long_________	
Eye Surgery	Yes	No	Date_____________ Please Explain____	

Are you pregnant? Y or N Do you drive? Y or N If, yes do you have any visual difficulty when driving? Y or N

Do you use tobacco/cigarettes? Y or N Do you use alcohol? Y or N Do you use any other substances/ recreational drugs? Y or N

Have you been exposed to or infected with any infectious or immune diseases? Y or N______________________________

List of Allergies____

List of Medication____

Reviewed ______________________Date_____________________ (Over)

HIPAA Privacy Notice

This location does not sell your personal information to any third parties. Copies of the HIPAA Privacy Act may be requested.

I acknowledge and agree that this location may submit any vision or medical claims to receive reimbursement.

____ ___________________

Patient Signature or Patient's Legal Representative Date

Information and Consent for Advance Testing

Dilation

Our office is committed to the highest standard of optometric care and the prevention of eye diseases. In addition to your general eye exam, we may recommend dilation of your pupils to further evaluate the health of your eyes. Dilation is a procedure in which eye drops are administered to temporary enlarge the pupil. You may experience light sensitivity and blurry vision for a few hours afterwards. This allows for a full view inside the eye which can assist in the detection of many disorders such as

- Diabetes
- Macular Degeneration
- Hypertension
- Glaucoma
- Retinal Detachments
- Cataracts

There is a Fee of $30 for the test

I **agree** to the advance testing __________ I understand the Importance of dilation but **decline** __________

Visual Fields

A visual field screening evaluates the different areas of your peripheral vision. The screening will determine if there is any vision loss as a result of damage to the retina and optic nerve. A vision screening will give the doctor more information to better evaluate the health of your eyes and the results are immediate. Some diseases which cause peripheral vision loss include

- Glaucoma
- Optic Nerve Disease
- Retinal Detachments
- Diabetes
- Hypertension
- Tumors

There is a $15 fee for the test.

I **agree** to Vision Field_____________ I understand the importance of visual fields but **decline**_________