

**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 phone numbers provided to call patient with reminders for their 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 explain location, frequency, and degree of discomfort \_\_\_\_\_

Date of last medical exam with your primary care physician \_\_\_\_\_

**Visual and Medical History**

Do you have any of the following?

<b>Self</b>				<b>Family</b>	
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 Medications \_\_\_\_\_

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 your insurance to receive reimbursement.

\_\_\_\_\_  
Patient Signature or Patient’s Legal Representative

\_\_\_\_\_  
Date

**Retinal Imaging**

The new standard in eye care is retinal imaging. These images are captured with our retinal imaging camera. Your images will be used to assess the health of the eye and can reveal the beginning stage diseases. This technology gives your doctor the means to track the health of the eye over time by comparing images year over year. These images will give the doctor a view similar to dilation without the side effects and results are immediate. Retinal Imaging is recommended for patients with a history of any of the following:

- |                  |                     |                      |
|------------------|---------------------|----------------------|
| High Minus Rx    | Retinal Holes       | Macular Degeneration |
| High Cholesterol | High Blood Pressure | Patients over 40     |
| Floaters         | Glaucoma            | Diabetes             |

**There is a fee of \$29 for the images.**

I **agree** to the advance testing \_\_\_\_\_ I understand the importance of Retinal Images but **decline** \_\_\_\_\_

**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 the entire eye. Dilation is a procedure where eye drops are administered to temporary enlarge the pupil. You will experience mildly blurry vision and light sensitivity for a few hours afterwards. This allows a full view inside of the eye which can assist in the detection of disorders such as

- |                      |                     |
|----------------------|---------------------|
| Diabetes             | Glaucoma            |
| Hypertension         | Retinal Detachments |
| Macular Degeneration | Cataract            |

**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 Screening**

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. A screening will give the doctor more information to better the health of your eyes and results are immediate. Some diseases which cause peripheral vision loss include

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

**There is a \$15 fee for the test.**

I **agree** to Vision Field \_\_\_\_\_ I understand the importance of visual fields but **decline** \_\_\_\_\_

