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 physican_____

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 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

OCT/ Retinal Imaging

The OCT (Optical Coherence Tomography) is like an MRI of the eye, but painless and quick. It takes approximately 10-15 seconds per eye. The results provide high definition cross sections of the eye. This advanced technology can help detect potential vision threatening diseases in their early stages when they are most treatable. More importantly, the doctor can see the layers in your eye that are invisible with traditional eye examination techniques.

This is the new standard of care and will be offered to every patient. The patient will be able to see their eye in high definition and in three dimensional cross sections during their eye exam. The doctor will go over the results with each patient.

Insurance typically does not cover any advanced screening technology beyond the general exam. This will be done as an enhancement to the general eye exam for a fee of **$49.00**. You may choose to do the Retinal imaging only for **$29.00.**

I agree to advance testing (OCT/Retinal Imaging) _____

OR

I agree to Retinal imaging ONLY _____

I understand the importance of the advanced testing 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 $25 fee for the test.

I **agree** to Vision Field_____ I understand the importance of visual fields but **decline**_____