Welcome to our Office

PATIENT INFORMATION

Patient Name _____ Age _____ Today's Date _____
If Married, Name of Spouse _____ If Minor, Parent's Name _____
Title: Mr. Mrs. Miss Ms. Other _____ Your Sex: ☐ Male ☐ Female
Address _____ City _____ State _____Zip Code _____
Cell Phone ( ) _____ Email Address _____
Phone ( ) _____ Social Security # _____ Date of Birth _____
Occupation _____ Medicare # _____
Does your work require special vision care? _____ If so, please explain _____
List Activities/Hobbies you participate in that may require special vision care _____
Do you wear glasses? ☐ Yes ☐ No If yes, how old is your present pair? _____
Are you wearing contact lenses? ☐ Yes ☐ No
Are you interested in wearing contact lenses? ☐ Yes ☐ No
Are you interested in Laser Vision Correction? ☐ Yes ☐ No
Any special Eye or Vision problems? ☐ Yes ☐ No If yes, please explain _____
_____
Date of Last Exam _____ Reason for Today's visit _____
How were you referred to our office? _____

VISION INSURANCE INFORMATION

Vision Insurance Name _____ ID # _____
Policy Holder Name _____ Date of Birth_____

MEDICAL HISTORY

Medical Dr. _____ Last Visit _____ Phone ( ) _____
Do you have?

Heart Disease	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Are you taking any medications? (Please list)	
High Blood Pressure	☐ Yes ☐ No	Lung Disease	☐ Yes ☐ No	_____	
Kidney Problems	☐ Yes ☐ No	Cancer	☐ Yes ☐ No		
Ulcers	☐ Yes ☐ No	Sinus Problems	☐ Yes ☐ No	_____	
Thyroid Problems	☐ Yes ☐ No	Allergies	☐ Yes ☐ No		
Headaches	☐ Yes ☐ No	If yes, explain _____			

Does anyone in your family have any medical problems? ☐ Yes ☐ No If yes, please explain _____
_____

OCULAR HISTORY

Blurred Vision	☐ Yes ☐ No	Cataracts	☐ Yes ☐ No	Dry Eyes	☐ Yes ☐ No
Double Vision	☐ Yes ☐ No	Eyelid Problems	☐ Yes ☐ No	Crusty Eyelid	☐ Yes ☐ No
Tired when reading	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Eye Injury	☐ Yes ☐ No
Spots	☐ Yes ☐ No	Tearing	☐ Yes ☐ No	Lasik/Prk/Pk	☐ Yes ☐ No

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS OR OTHER INSURANCE BE MADE EITHER TO ME OR ON MY BEHALF TO DR. _____ FOR ANY SERVICES FURNISHED TO ME BY THAT DOCTOR. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME, TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS, ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES. I AM RESPONSIBLE FOR ANY CHARGES NOT COVERED BY MY INSURANCE COMPANY.

LIFETIME PATIENT SIGNATURE _____ DATE _____

NOTICE OF PRIVACY PRACTICES

I, _____ hereby acknowledge receipt of the Notice of Privacy Practices given to me.

Signature _____ Date _____

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PATIENT DILATION INFORMATION AND CONSENT

A complete and thorough eye health examination includes assessing the health of the internal ocular structures.

Dilation is achieved by instilling drops in the eye, and it takes approximately 20-30 minutes for the drops to take effect. You may experience some blurred vision (especially up close) and sensitivity to light. These symptoms usually disappear within 4 hours.

I CONSENT TO DILATION _____

Signature of patient (or guardian if under 18) Date

I REFUSE DILATION _____

Signature of patient (or guardian if under 18) Date

READ THE FOLLOWING IF YOU WANT A CONTACT LENS EXAM AND SIGN:

"I understand that contact lenses are a medical device and that they have a limited useful life span that must be regularly evaluated by the doctor. I understand that contact lenses have many benefits, but as with any other drug or medical device, they are not without possible risks. A small percentage of wearers develop serious complications which can lead to permanent eye damage. I am aware that serious complications can result from me not following the instructions provided. **I understand that it is essential to have periodic follow up examinations so that the doctor can check for any problems that may develop.**

I will remove my lenses and promptly seek care if I experience any unexplained eye pain, redness, or vision changes."

Professional fee for a contact lens exam covers 3 to 4 follow up evaluations or as recommended by the optometrist within 90 days from today.

Date: _____ Signature of Patient: _____