Bright Eyes
Family Vision Care

Please complete both sides of this form.

WELCOME TO OUR OFFICE

Patient Information

Today's Date: _____

Last Name: _____

First Name: _____ MI: ___

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____

Cell Phone: _____

Gender: M F Date of Birth: _____

Patient SSN: _____

Marital Status: _____

Employer: _____

Occupation: _____

Circle how you would prefer to receive reminders for appointments, eyeglass pickup and special events.

Email Text to Cell Phone Phone Call /Postcard

Email: _____

Lifestyle Questions

Are you planning on purchasing glasses today?

❑ Yes ❑ No ❑ Maybe

Are you planning on getting a contact lens evaluation today? (Additional fees apply.)

❑ Yes ❑ No ❑ Maybe

Do you…? (Check all that apply)

❑… wear prescription glasses?
❑… have ultraviolet protection sunwear?
❑… have "back up" prescription eyewear?
❑… wear contact lenses?

If so, what kind? _____

Solution Used: _____

❑… experience discomfort with your contacts?
❑… work at a computer? _____ hrs/day
❑… have interest in a non-surgical vision correction?
❑… want information on LASIK surgery?
❑… have children?

What are your hobbies? _____

_____

How did you find out about our office?

Where have you seen us? *(Check all that apply.)*

❑ Insurance List ❑ Google
❑ World of Westchase ad ❑ Our Website
❑ Another Patient: _____
❑ Another doctor: _____
❑ Social Media: _____
❑ Other: _____

Patient Eye History

What specific problems do you have with your vision, eyes, glasses, or contact lenses?

_____

_____

Date of Last Eye Exam: _____

Previous Eye Doctor: _____

Have you ever experienced the following?

(Check all that apply.)	**Currently**	**In the Past**
Blurry Vision without glasses/CLs	❑	❑
Blurry Vision with glasses/CLs	❑	❑
Cataracts	❑	❑
Macular Degeneration	❑	❑
Glaucoma	❑	❑
Retinal Problems	❑	❑
Dry Eye	❑	❑
Floaters/ Spots	❑	❑
Flashes of light	❑	❑
Red Eye	❑	❑
Itchy/ Burning eyes	❑	❑
Watery Eyes/ Tearing	❑	❑
Discharge	❑	❑
Eye Fatigue/ Tired Eyes	❑	❑
Pain/ Irritation	❑	❑
Sensitivity to Light	❑	❑
Headaches/Migraines	❑	❑
Double Vision	❑	❑
Vision Loss	❑	❑
Eyelid Problems	❑	❑
"Lazy Eye"/Amblyopia	❑	❑
Eye turn/Crossed eye	❑	❑
Eye Injury/ Trauma/Abrasion	❑	❑
Eye Infections	❑	❑
Allergy	❑	❑

Other vision concerns: _____

_____

Patient Medical History

Primary Physician: _____

Location: _____

Date of Last Physical Exam: _____

❑ AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Bright Eyes Family Vision Care to release any medical findings or results for medical benefit to my primary physician.

Have you ever been diagnosed or treated for the following health problems?

❑ Cancer: _____ ❑ Digestive: _____

❑ Ear/Nose/Throat ❑ Kidney

❑ Sinus Problems ❑ Genitourinary

❑ Neuro: _____ ❑ Muscle/Bone/Arthritis

❑ Psych: _____ ❑ Skin: _____

❑ Cardio: _____ ❑ Diabetes/Endocrine

❑ High Blood Pressure ❑ Blood/ Lymph

❑ Respiratory/ Asthma ❑ Cholesterol

❑ Allergies: _____ ❑ Reproductive

❑ Immune System ❑ STD: _____

❑ Other Health Problems: _____

_____

_____

CURRENT MEDICATIONS (Rx or Over-the-Counter):
(*List all medications including eye drops, vitamins, etc.*)

_____

_____

Allergies to medications? ❑ Yes ❑ No

If so, what medications? _____

_____

Have you had any ocular surgeries? ❑ Yes ❑ No

If so, please describe: _____

_____

Is there a possibility that you are pregnant? ❑ Yes ❑ No

Tobacco: ❑ None ❑ Former Smoker ❑ < 1 pack/day
❑ 1-2 packs/day ❑ >2 packs/day

Alcohol: ❑ None ❑ Social drinker
❑ 1-2 drinks/day ❑ Above Average Use

Narcotics/ Drugs: ❑ None ❑ Recreational : _____

Family Medical/ Eye History

Have any family members been diagnosed with any of the following? Which family member?

Blindness	❑	_____
Cataracts	❑	_____
Glaucoma	❑	_____
Eye Turn	❑	_____
Retinal Problems	❑	_____
Macular Degeneration	❑	_____
Diabetes	❑	_____

Privacy Practices for Health Information

NOTICE OF PRIVACY PRACTICES: I/We have been offered a copy of Bright Eyes Family Vision Care's statement on privacy practices.

AUTHORIZATION TO RELEASE INFORMATION: I/We hereby authorize Bright Eyes Family Vision Care to release any medical information that may be necessary for medical benefit or to obtain payment for services. This includes vision plans or medical insurances.

CONSENT FOR TREATMENT: I/We hereby authorize Bright Eyes Family Vision Care to administer diagnostic and medical procedures as necessary for proper health care.

_____ _____
Patient Signature Date

Dilation Consent

Dr. Bonilla-Warford and Dr. Knighton recommend a dilated eye examination to fully assess the health of your eyes. With dilation, drops are placed in the eyes to enlarge the pupils so that the doctor can carefully examine both eyes for any diseases. Dilation will cause sensitivity to light and will make your near vision temporarily blurry. Our office will provide you with disposable sunglasses. Dilation is routine and does not cost extra.

If you have any questions, the Doctor will be happy to answer them. Please INITIAL one option below, indicating that you have read and understood the dilation consent.

___ Yes, I consent to have my eyes dilated today.

___ No, I do not consent to have my eyes dilated, and I agree to hold the practice harmless as a result.

_____
Patient Signature

Retinal Photographs

Our doctors recommend digital retinal photographs for all patients as part of the yearly eye exam. These images become a permanent record in your medical file that allows the doctors to better detect, diagnose and document potential retinal disorders year after year. For most people, the fee for the procedure ($39) not covered by vision plans or insurances. If you have any questions, please ask the tech or the doctor.