Patient Information

Patient Name_____

Street Address_____

Apt# _____City_____

State_____ Zip_____

Home Phone_____

Work Phone_____

Cell Phone_____

Email address_____

Sex_____ Age_____ Birthdate____/____/____

Guardian (if minor)_____

Occupation _____

Last Eye Exam_____/_____/_____

Last Eye Doctor_____

Do you wear Glasses ☐ Yes ☐ No

Do you wear Contact Lenses ☐ Yes ☐ No

What kind? _____Daily _____Overnight

_____Soft _____Gas Permeable

Do you experience Computer Eyestrain ☐ Yes ☐ No

What is your average computer use? _____hrs/day

How did you choose our office? ☐Relative/friend

☐Previous Patient ☐ Yellow pages ☐ Insurance

Do you have Vision Insurance? ☐ Yes ☐ No

If yes, insurance carrier_____

Do you have Health Insurance? ☐ Yes ☐ No

If yes, insurance carrier_____

Reason for Today's Visit:

☐ Glasses ☐ Contact Lenses ☐ Other _____

Medications

☐ Not taking any medications (Include over the counter and home remedies)

_____

_____

_____

Are you allergic to any medication? ☐ No ☐ Yes_____

Ocular History/Medical History	Yourself	Relative	
Glaucoma	☐	☐	_____
Cataract	☐	☐	_____
Macular Degeneration	☐	☐	_____
Surgery	☐	☐	_____
Lazy Eye	☐	☐	_____
Retinal Hole/Detachment	☐	☐	_____
Eye Injury	☐	☐	_____
High Blood Pressure	☐	☐	_____
Diabetes	☐	☐	_____
Cholesterol	☐	☐	_____

Social History (This information is kept strictly confidential. However, you may discuss this portion directly with the Doctor if you prefer.)

Do you drive? ☐ No ☐ Yes

Tobacco Use ☐ No ☐ Occasional ☐ Frequent

Alcohol Use ☐ No ☐ Occasional ☐ Frequent

HIPAA PRIVACY

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") we are required to maintain the privacy of your protected health information and provide you with notice of our legal duties and privacy practices with respect to such protected health information.

I_____ have received and reviewed the Notice of Privacy Practices
Patient's Name

CONSENT FOR DILATION

Our office offers dilation as a no cost addition to your examination. It is required to be performed on all new patients during the initial visit to this office. Dilating your eyes gives the doctor an expanded view of the inside of your eyes, and is helpful in detecting cataracts, glaucoma, retinal detachments and other ocular disorders.
NOTE: Due to the enlargement of the pupils, dilation may affect the comfort of some patients when reading or driving (usually 2 to 3 hours), and create sensitivity to bright lights (usually 3 to 4 hours).

"I understand the risks and benefits associated with pharmacologic dilation of the pupils and have made my decision via informed consent"

_____I ACCEPT Dilation _____I DECLINE Dilation

_____ I would like to RESCHEDULE DILATION

RETINAL PHOTOGRAPHY

We are excited to announce that we have incorporated into our comprehensive eye examination a newly sophisticated computerized retinal camera, which enables us to provide a more thorough analysis of the insides of your eyes. These computer images can help the doctor detect DIABETIC problems, HIGH BLOOD PRESSURE damage, GLAUCOMA, MACULAR DEGENERATIONS, RETINAL BREAKS, PRE-CANCEROUS LESIONS and many other diseases in the back of the eye. We strongly recommend all patients have this test performed so that the image can be monitored for any future changes.

THE FEE FOR RETINAL PHOTOGRAPHY IS $20.00 FOR BOTH EYES (Screening fee is NOT COVERED by insurance)

_____I ACCEPT Retinal Photography today _____I DO NOT accept Retinal Photography today

INSURANCE INFORMATION/ AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I request payment of authorized Medicare and other insurance benefits to be made to me or my behalf to Eye Care Professionals, P.A. for any services rendered. I authorize any holder of medical information about me, to release the health care financing administration and its agents, any information needed to determine these benefits payable for related services. This assignment will remain in effect until revoked in writing.
Please be advised that professionals fees for Doctor Services are payable separately from eyeglass and/or contact lens materials costs.
Payment is due at time of service

By signing below I acknowledge that I have read and understand all the information on this page.

Patient/Guardian Signature:_____Date:_____

Review of Systems Do you currently have or have you ever been diagnosed with any problems in the following areas:

Allergic/Immunologic	Yes	No
Drug Allergies	☐	☐
Environmental Allergies	☐	☐
Rheumatoid Arthritis	☐	☐
Lupus	☐	☐
Other	☐	☐

Musculoskeletal	Yes	No
Fibromyalgia	☐	☐
Muscular Dystrophy	☐	☐
Osteoarthritis	☐	☐
Ankylosing Spondylitis	☐	☐

Gastrointestinal	Yes	No
Crohn's Disease	☐	☐
Colitis	☐	☐
Ulcer	☐	☐
Digestive	☐	☐

Constitutionals	Yes	No
Developmental Disorders	☐	☐
Weight Loss	☐	☐
Fever	☐	☐
Fatigue Syndrome	☐	☐
Trauma	☐	☐

Psychiatric	Yes	No
Depression	☐	☐
Panic Disorder	☐	☐
Schizophrenia	☐	☐

Hematologic	Yes	No
Anemia	☐	☐
Large Volume Blood Loss	☐	☐
Leukemia	☐	☐

Endocrine	Yes	No
Diabetes Non-Insulin	☐	☐
Diabetes - Insulin	☐	☐
Thyroid Dysfunction	☐	☐
Hormonal Dysfunction	☐	☐

Eyes	Yes	No
Glaucoma	☐	☐
Cataracts	☐	☐
Macular Deg.	☐	☐
Surgery	☐	☐
Inflammatory Disorder	☐	☐
Blurred Vision	☐	☐
Double Vision	☐	☐

Cardiovascular	Yes	No
Heart Disease	☐	☐
High Blood Pressure	☐	☐
Stroke	☐	☐
Vascular Disease	☐	☐

Neurological	Yes	No
Multiple Sclerosis	☐	☐
Epilepsy	☐	☐
Alzheimer's Disease	☐	☐
Parkinson's Disease	☐	☐
Cerebral Palsy	☐	☐

Genitourinary	Yes	No
STD	☐	☐
Pregnant/Nursing	☐	☐

Ear, Nose, Mouth, Throat *(Currently experiencing now)*	Yes	No
Upper Respiratory Track Infection	☐	☐
Ear Ache	☐	☐
Runny Nose	☐	☐
Sore Throat	☐	☐
Ringing/Tinnitis	☐	☐

Respiratory	Yes	No
Cigarette Smoker	☐	☐
Asthma	☐	☐
Bronchitis	☐	☐
Emphysema	☐	☐

Integumentary	Yes	No
Eczema	☐	☐
Rosacea	☐	☐
Psoriasis	☐	☐
Other	☐	☐

If you answered yes to any of the above, or have a condition not listed, please explain:

_____

_____