WELCOME TO TSO-LUMBERTON

Patient Name: _____ Marital Status: _____ Gender M or F

Birthdate: _____ Age: _____ Social Security # _____

Mailing Address _____ City/State/Zip _____

Home Phone _____ Cell # _____ Work # _____

Occupation: _____ Employer: _____

Primary Doctor: _____ Special Needs: _____

Doctor Phone # _____ Doctors Location: _____

If a Student: Grade: _____ School Name: _____

Email Address: _____ Referred By: _____

If under 18 Parent/Guardian name: _____

Patients Mothers Maiden Name: _____ Birth State: _____

Race: _____ Ethnicity: _____ Primary Language: _____

INSURANCE INFORMATION

Your vision plan will not pay for the visit if there are any general health issues or the doctor finds any disease process at all. The vision plan is designed for well care visits for the prescription of glasses or contact lenses. Your medical plan is required to be billed if your visit is in any way medical.

Vision Plan Name _____

Subscriber Name: _____

Subscriber SS#: _____ DOB: _____

Primary Medical Insurance: _____

Policy #: _____ Group #: _____

Subscriber Name: _____

Subscriber SS#: _____ DOB: _____

Secondary or Supplemental Insurance: _____

ADVANCED BENEFICIARY NOTICE (ABN)

PAYMENT OF SERVICES IS DUE TODAY. YOU ARE RESPONSIBLE FOR BALANCES NOT PAID BY INSURANCE.
PLEASE PRESENT INSURANCE INFORMATION BEFORE EXAMINATION.

HIPPA

THIS OFFICE COMPLIES WITH ***HIPPA*** AND YOU MAY HAVE A COPY OF THE **NOTICE OF PRIVACY PRACTICE.**
PLEASE CIRCLE ONE I WANT A COPY I DO NOT WANT A COPY

SIGNING BELOW INDICATES THAT YOU HAVE READ AND UNDERSTAND THIS NOTICE.

SIGNATURE _____ DATE _____

PATIENT _____

TODAY'S VISIT

ID # _____ DOB _____

How can we help you today? Briefly tell us any problems you are experiencing. Medical insurance will only cover if there is a medical reason for the exam, such as loss of vision, headaches, eye redness, eye pain, itching or burning, glaucoma, cataracts, floaters, dry eyes, etc.

_____

_____

Please tell us about your eye problem:

Which eye has the problem?	☐Right	☐Left	☐Both
How long has the problem been occurring?	☐Short term	☐Long term	
Does the problem cause vision loss or blur?	☐Vision Loss	☐Blur	
Did the problem occur suddenly or gradually?	☐Sudden	☐Gradual	
How severe is the problem?	☐Mild	☐Moderate	☐Severe
Does anything help the problem?	☐Nothing	☐Nothing has been tried	
	☐Other, explain _____		
How long does the problem last?	☐Intermittent	☐Constant	
Are there associated symptoms?	☐No	☐Yes, explain _____	

Do you ever experience any of the following (please check):

☐ Dryness	☐ Redness	☐ Burning/Itching	☐ Watery Eyes	☐ Sandy/Gritty Feeling
☐ Discharge	☐ Glare/Halos	☐ Light Sensitivity	☐ Tired Eyes	☐ Eye Soreness
☐ Squinting	☐ Double Vision	☐ Flashes of Light	☐ Floaters	☐ Eye Infections

OCULAR HISTORY

Are you having any problems with your current contact lenses or glasses? If so, please explain:

_____

When was your last eye exam? _____

Who was the doctor? _____

Do you wear glasses? ☐Yes ☐No

How old are they? _____

Do you wear contact lenses? ☐Yes ☐No

What kind? _____

How old are they? _____

Do you sleep in them? ☐Yes ☐No

PERSONAL AND FAMILY MEDICAL / EYE HISTORY

Is there any personal or family history of any of the following? (Please check all that apply.)

	You	Relative (what is their relationship to you?)
Glaucoma	☐	☐ _____
Cataracts	☐	☐ _____
Macular Degeneration	☐	☐ _____
Eye Injury	☐	☐ _____
Retinal Problems	☐	☐ _____
Blindness	☐	☐ _____
Crossed Eyes	☐	☐ _____
Lazy Eye	☐	☐ _____
Diabetes	☐	☐ _____
Cancer	☐	☐ _____
Heart Disease	☐	☐ _____
High Blood Pressure	☐	☐ _____
High Cholesterol	☐	☐ _____
Arthritis	☐	☐ _____
Thyroid	☐	☐ _____
Other	☐	☐ _____

Please list all major personal injuries, surgeries, and / or hospitalizations:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Do you spend any time on the computer? ☐ Yes ☐ No

Hours per Day _____

(please complete other side)

MEDICATIONS

List any and all medications you take (even occasionally) and for what illness (including aspirin, home remedies, oral contraceptives, over the counter medications, vitamins, etc.). If you have a pre-written list, feel free to present that to the technician or doctor.

_____

_____

Do you have ANY allergies to medications? ☐Yes ☐No

What medications? _____

OVERALL HEALTH

Height _____ Weight _____

Please check all that apply:

Constitutional
- ☐ Fatigue
- ☐ Headaches
- ☐ Sleep Problems
- ☐ Sudden Weight Gain / Loss

Cardiovascular
- ☐ Chest Pain
- ☐ Heart Disease
- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Leg/Arm Swelling
- ☐ Palpitations
- ☐ Vascular Disease

Ear/Nose/Throat
- ☐ Abnormal Taste
- ☐ Difficulty Swallowing
- ☐ Dry Throat/Mouth
- ☐ Hearing Loss ☐ Right ☐ Left
- ☐ Ringing in Ears
- ☐ Sinus Problems
- ☐ Sore Throat/Cough
- ☐ Stuffy Nose

Respiratory
- ☐ Asthma
- ☐ Bronchitis
- ☐ COPD
- ☐ Emphysema
- ☐ Shortness of Breath
- ☐ Tuberculosis

Gastrointestinal
- ☐ Acid Reflux
- ☐ Constipation
- ☐ Diarrhea
- ☐ Ulcers

Genitourinary
- ☐ Bladder Problems
- ☐ Frequent Thirst
- ☐ Frequent Urination
- ☐ Kidney Problems
- ☐ Ovarian/Uterine Problems
- ☐ Prostate Problems

Musculo-Skeletal
- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Joint Pain
- ☐ Muscle Pain
- ☐ Osteoporosis
- ☐ Rheumatoid Arthritis
- ☐ Scoliosis

Integumentary
- ☐ Brittle Nails/Hair
- ☐ Dryness
- ☐ Eczema
- ☐ Psoriasis
- ☐ Sores/Rashes

Neurological
- ☐ Dizziness
- ☐ Epilepsy/Seizures
- ☐ Migraines
- ☐ Stroke

Psychiatric
- ☐ Anxiety
- ☐ Compulsive Behavior
- ☐ Depression
- ☐ Dementia
- ☐ Nervousness
- ☐ PTSD

Endocrine
- ☐ Diabetes
  - ☐ Type 1 ☐ Type 2
  - ☐ Pre-Diabetes
  - ☐ Gestational
- ☐ Thyroid Disorder

Hematologic/Lymphatic
- ☐ Anemia
- ☐ Bleeding problems
- ☐ Leukemia
- ☐ Lymphoma
- ☐ Node Swelling

Allergic/Immunologic
- ☐ Hay fever
- ☐ HIV/Aids
- ☐ Lupus
- ☐ Medicine Allergies
- ☐ Seasonal Allergies

Social History

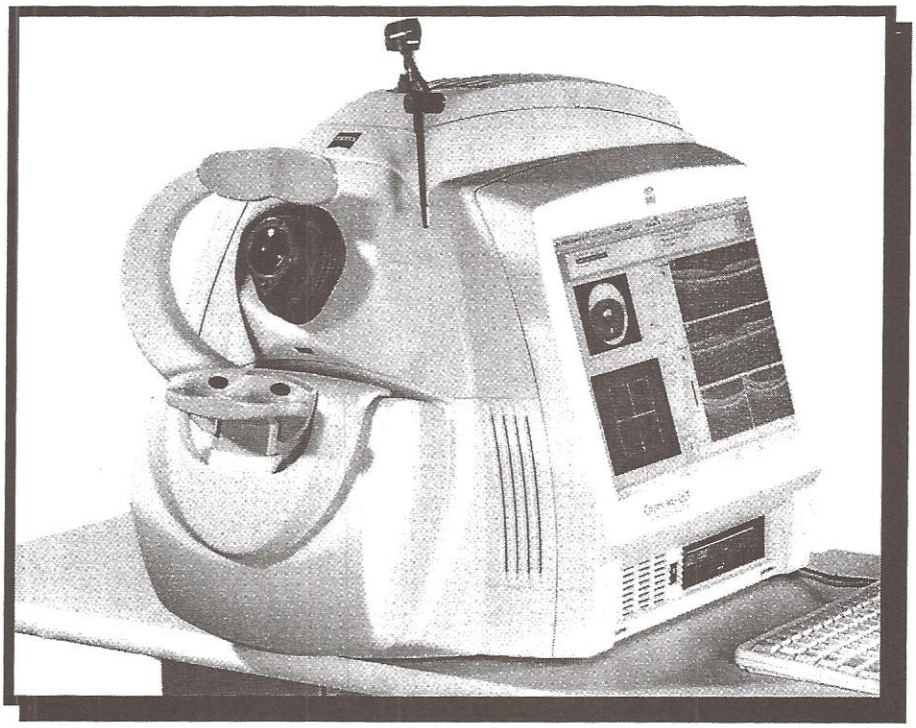
This is confidential and may be discussed directly with the doctor if desired.

Do you use any of the following? If so, how often?
- ☐ Tobacco _____
- ☐ Drugs _____
- ☐ Alcohol _____

Have you been exposed to or infected with any of the following?
- ☐ Gonorrhea
- ☐ HIV/Aids
- ☐ Hepatitis
- ☐ Syphilis

TSO-LUMBERTON
SHAWN L. DUNNIGAN, O.D.

OCT Screening



OUR OFFICE HAS ACQUIRED A NEW AND HIGHLY SOPHISTICATED COMPUTERIZED INSTRUMENT ENABLING US TO PROVIDE DETAILED IMAGES FROM THE BACK OF YOUR EYES. OCT CAN ASSIST US IN EARLY DETECTION OF GLAUCOMA, MACULAR DEGENERATION, DIABETES, AND OPTIC NERVE DISEASE).

WE RECOMMEND THAT OUR PATIENTS RECEIVE THIS TEST AS PART OF THEIR COMPREHENSIVE VISUAL ANALYSIS. THE FEE FOR THIS PROCEDURE IS $30.

SINCE OUR OFFICE STAFF PERFORMS THIS TEST PRIOR TO THE EXAM, PLEASE TELL OUR FRONT DESK STAFF IF YOU WOULD LIKE TO HAVE THIS PROCEDURE PERFORMED. IF YOU HAVE ANY QUESTIONS, THE DOCTOR WILL BE HAPPY TO DISCUSS THIS IN MORE DETAIL.

I APPROVE OF AN EXTRA $35 FEE FOR THIS PROCEDURE. _____
(SIGNATURE & DATE)

I DO NOT APPROVE OF HAVING THIS SPECIAL TESTING TODAY AND FULLY UNDERSTAND ITS' IMPORTANCE TO BETTER UNDERSTANDING MY EYE HEALTH. _____
(SIGNATURE & DATE)

Dr. Shawn L. Dunnigan

Dilation of the Eyes

If you have a condition such as diabetes, cataracts, high blood pressure, headache, high nearsightedness, symptoms of flashing lights or floaters, glaucoma or a family history glaucoma, or you have not had your eyes dilated in the past two years, you are urged to have your eyes dilated. Dilation involves placing drops in your eyes to enlarge the pupil size. This allows the doctor to examine the retina (back of the eye) more thoroughly.

With Dilation of the eyes you will experience the following effects:

1) increased sensitivity to light.
   We will provide you with temporary sunglasses)
2) a slight blurring of your distance vision.
3) inability to focus up close.

These effects will last 2-6 hours. Due to these effects we may recommend that someone drive you home. We also recommend that you take extra care in walking up and down stairs or curbs and driving. If your eyes become painful or red, or you develop a headache or nausea, please return to our office immediately.

There is an additional charge of $20.00 for this procedure. Medicare, Medicaid and most major insurance's will cover the cost of an eye exam with dilation when it is medically necessary.

YOU MUST CHECK ONE

_____ I wish to have my eyes dialated.

_____ I do not wish to have my eyes dilated and assume the responsibility of having an eye exam without dilation.

Patient's Signature _____ Date _____
(Parent if patient is a minor)