EYE SITE

PATIENT INFORMATON

Patient Name: Last _____First_____MI_____ Date____/_____/_____

Birth Date____/_____/_____Age_____ ☐ M ☐ F

Social Security_____-_____-_____

Home Phone_____

Cell Phone_____

Work Phone_____

Marital Status ☐ Single ☐ Married ☐ Other

Emergency Contact_____

Relation_____Phone_____

Email_____

Address_____ Apt_____

City_____ST_____Zip_____

Occupation_____

Employer/School_____ ☐ Not Employed

How did you hear about us? ☐ Location ☐ Insurance ☐ Internet ☐ Care Credit

☐ Friend/Family (Name)_____ ☐ Ad _____

Parents Names (if under age 18) _____

If I need a prescription, I am interested in a: ☐ Glasses Exam ☐ Contacts Lens Exam _____

Date of your last eye exam _____ How old are your glasses?_____ When was your last physical?_____

Current Medications: ☐ **NONE** _____

_____

Drug Allergies: ☐ **NONE** _____

Females: Are you currently nursing or pregnant? ☐ No ☐ Yes (How many months?) _____

FAMILY HISTORY: ☐ **NONE** ☐ Glaucoma ☐ Eye Turn ☐ Blindness ☐ Macular Degeneration (AMD) ☐_____

SOCIAL HISTORY: Hobbies/ Sports/ Activities _____

Do you smoke? ☐ Never ☐ Former Smoker ☐ Yes (How much?) _____

Do you drink alcohol? ☐ No ☐ Yes (How much?) _____

Do you use recreational substances? ☐ No ☐ Yes (Please Name) _____

EYE HISTORY: ☐ **NONE**

☐ Cataracts_____
☐ Eye injury_____
☐ Eye surgery_____
☐ Eye turn (Strabismus)_____
☐ Glaucoma_____
☐ Lazy eye (Amblyopia)_____
☐ Macular Degeneration_____
☐ Retinal disease_____
☐ _____
☐ _____

CURRENT ISSUES: ☐ **NONE**

☐ Burning eyes
☐ Double vision
☐ Dry eyes
☐ Excessive tearing
☐ Eye pain
☐ Floaters
☐ Flashes of light
☐ Glare/Light sensitive
☐ Itchy eyes
☐ Redness
☐_____
☐_____

REVIEW OF SYSTEMS (ROS): ☐ **NONE**

General/ Constitutional: ☐ Significant weight change_____
Ear/ Nose/ Mouth/ Throat: ☐_____
Cardiovascular: ☐ Hypertension ☐ High Cholesterol ☐ Heart Dz
Respiratory: ☐ Asthma ☐ COPD ☐ Tuberculosis _____
Gastrointestinal: ☐ GERD_____
Skin/ Integumentary: ☐ Rosacea_____
Neurological: ☐ Migraines ☐ Headaches ☐ Multiple Sclerosis
Pyschiatric: ☐ Depression ☐ Anxiety_____
Endocrine: Diabetes ☐Type 1 ☐Type 2 ☐ Thyroid _____
Blood/ Lymph: ☐ Anemia_____
Allergic: ☐ Seasonal _____
Immunologic: ☐Lupus ☐AIDS/HIV _____
Cancer: Type_____☐ Chemotherapy ☐ Radiation
☐_____

HIPAA ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

The law requires that Eye Site makes every effort to inform you of your rights related to your personal health information.

I have been given the opportunity to view and keep a copy for my records of the "Notice of Privacy Practices" of Eye Site. This notice provides information on how my health information may be used and disclosed.

Patient/ Representative Signature _____Relation_____Date_____/_____/_____

ADDITIONAL EYE HEALTH TESTS

The following optional tests assist in the early detection of diseases and are recommended annually for everyone of all ages. Preventative eye care is key for ensuring good vision eye health.

1. **Pupil Dilation** uses eye drops to enlarge the pupils for a better view of the back of the eyes. It helps detect cataracts and diseases such as glaucoma, macular degeneration, tumors, and retinal holes, tears, and detachments, and diabetic and hypertensive retinopathy. Most can drive after dilation, but near vision will blur for approximately 4-6 hours with increased light sensitivity. The doctor will examine the eyes after approximately 20-30 minutes of receiving the eye drops. Dilation is required for all patients with diabetes, glaucoma or glaucoma suspect, or with a personal or family history of eye any diseases. Dilation is usually necessary for children ages 8 and under to obtain an accurate eyeglass prescription.

2. **Visual Field Testing** checks for blind spots in the central and peripheral vision and helps detect glaucoma, tumors, and retinal disorders. Visual Field Testing is recommended for all adults and can usually be performed reliably for children ages 10 and older.

Please sign below to indicate which test(s) you would like to have done today.

Signature_____ **I consent to Dilation**. (Included in cost of comprehensive exam)

Signature_____ **I consent to Visual Field Testing.** (**$25**, not covered by insurance)

Signature_____ **I do not consent to Dilation or Visual Field Testing today**

I release Eye Site and the doctors at Eye Site from any liabilities related to the failure to treat or detect any eye or systemic conditions due to the lack of diagnostic information obtained.