Simple Optical Inc.
Doctors of Optometry

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EYE GALLERY
DOCTORS OF OPTOMETRY

❒ New Patient ❒ Previous Patient

Last Name_____ First Name_____ DOB____/____/____
(mo / day / year)

Address_____ _____ ____ _____
(Street Address / City / State / Zip Code)

Best Phone #_____ Employer_____ Occupation_____

Email _____ Location of last eye exam _____ Year _____

Reason(s) for visiting our office today:

❒ Routine Eye Examination
❒ New glasses ❒ New contacts
❒ Glasses recently lost or broken
❒ Interested in trying contacts for the first time
❒ Interested in LASIK

Please check any that apply.

❒ Distance blur ❒ Near vision changes
❒ Dry eyes ❒ Eye fatigue
❒ Glare ❒ Halos
❒ Contact lens discomfort
❒ Computer use: ____ hours / day

❒ Eyes itch ❒ Eyes burn
❒ Eye pain ❒ Red eye(s)
❒ Flashes of light ❒ Floaters
❒ Peripheral vision changes
❒_____

Please indicate if you or any blood relatives have the following conditions:

	You	Relative	Who		You	Relative	Who
Heart Disease	no | yes	no | yes	_____	Eye Injuries	no | yes		
High Blood Pressure	no | yes	no | yes	_____	Eye Surgeries	no | yes		
High Cholesterol	no | yes	no | yes	_____	Cataracts	no | yes	no | yes	_____
Thyroid	no | yes	no | yes	_____	Glaucoma	no | yes	no | yes	_____
Multiple Sclerosis	no | yes	no | yes	_____	Retinal Issues	no | yes	no | yes	_____
Migraines	no | yes	no | yes	_____	Lazy Eye	no | yes	no | yes	_____
Diabetes (select type below)	no | yes	no | yes	_____	Macular Degeneration	no | yes	no | yes	_____
Type I Type II		Type I Type II		Other_____			

Do you have allergies to medications? ❒Yes ❒No If yes, please describe _____

Are you pregnant or nursing? ❒Yes ❒No (discuss dilation alternatives with the doctor if you are pregnant or nursing)

Please list current medications (including pain relievers, birth control, vitamins and supplements) also list any **Eye Specific Medications** including over the counter items and/or drops.

_____

Dilated Pupil Examination

Dilated pupil examination provides a more thorough eye health examination. Dilation allows the doctor to obtain a better view of the back of the eye. Retinal health, cataracts, glaucoma, and effects of systemic diseases such as diabetes or high blood pressure are more thoroughly evaluated with dilation. Drops are placed into the eye to enlarge the pupil. Temporary side effects include but are not limited to light sensitivity and blurred vision (primarily near vision). **These effects will diminish after 30 to 60 minutes but may last 4 to 6 hours**. Evaluate your vision prior to driving and protect your eyes with sunglasses. Dilation is included in the comprehensive eye exam on the day of the exam if you choose this option.

❒ **Yes**. I would like my **eyes dilated** today. I understand the side effects and the explanation above.
❒ **No.** I understand the risks and benefits and choose **not** to have my eyes dilated today.

Visual Field Screening

Visual Field Screening tests the pathway from the eye to the brain and peripheral/side vision. It may detect early glaucoma, brain tumors and other ocular pathologies. Testing usually takes less than 1 minute per eye and is painless.

❒ **Yes, I would like to perform the $10 Visual Field Screening.**

Insurance

❒ Not using Insurance ❒ Vision Insurance: Primary Insured's Full Name _____

Eye Care Plan Name_____ Primary Date of Birth _____ Primary ID # or last four numbers of SSN _____

NOTICE OF PRIVACY PRACTICES: I/We have been offered a copy of Eye Gallery's statement on privacy practices
AUTHORIZATION TO RELEASE INFORMATION: I/We hereby authorize Eye Gallery to release any medical or incidental information that may be necessary for medical benefit of in processing applications for financial benefit. This includes but is not limited to my insurance company, Rehabilitation Services, Social Security Administration, and Worker's Compensation.
CONSENT FOR TREATMENT: I/We hereby authorize Eye Gallery to administer diagnostic and medical procedures as may be necessary for proper health care.
I authorize the use of my personal information to process insurance benefits. I request insurance benefits be made on my behalf to Simple Optical Inc. for any services provided by Simple Optical, Inc. I understand that I will be responsible for any services not completely covered by insurance or any services which I am determined to be ineligible. My health history is updated, and I understand the all of the above.

Signature of Patient/Guardian_____ **Date**_____