OFFICE USE ONLY INS: _____
SPEC CL OV COMP
CL TYPE _____
F/U visit _____ D W M
OPTOS Y / N VF Y / N

Welcome to our office!

PATIENT INFORMATION

Name: _____ Date _____
Last MI First

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ _____ _____
Home Cell Work

Date of Birth: _____ Age: ____ Sex: Femal SSN (Last 4 Digits):_____

Occupation: _____ Employer: _____ Email:_____

Referred by: ☐ Insurance ☐ Family/friend: _____ ☐ Google ☐ ZocDoc ☐ Internet
☐ Walk-in ☐ Other _____

INSURANCE INFORMATION

Vision insurance:_____ Medical insurance:_____

Primary Insured's name: _____ Primary Insured's Date of Birth: _____

Primary Insured's SSN (Last 4 Digits):_____ Relationship to insured: ☐ Self ☐ Spouse ☐ Child

PATIENT OCULAR HISTORY

Reason for today's visit: _____

Date of last eye exam: _____ Name of eye doctor/location: _____

----------Please check all that apply below ----------

☐ Blurry Vision ☐ Dry Eyes ☐ Crossed Eyes ☐ Floaters ☐ Flashes of Light ☐ Glare/Light Sensitivity
☐ Lazy Eye ☐ Red Eyes ☐ Watery Eyes ☐ Cataracts ☐ Glaucoma ☐ Macular Degeneration
☐ Tired Eyes ☐ Eye Trauma ☐ Double Vision ☐ Blindness ☐ Retinal Disease ☐ Sandy/Gritty Sensation
☐ Itching ☐ Mucous Discharge ☐ Other: _____

Have you had any eye surgeries (ie. LASIK, PRK, Cataracts, etc)? ☐ No ☐ Yes

If yes, please list procedure and date:_____

Contact lenses:

Are you interested in wearing contact lenses? ☐ Yes ☐ No ☐ Maybe

Do you currently wear contact lenses and need an updated contact lens prescription? ☐ Yes ☐ No

If yes, what brand of contacts do you currently wear? _____

How often do you sleep in your contacts? ☐ Always ☐ Sometimes ☐ Never

How often do you dispose of your contacts? _____ Contact lens solution: _____

PATIENT MEDICAL HISTORY

----------Please check all that apply below ----------

☐ Diabetes	☐ Disability	☐ Depression/Psychosis
☐ High blood pressure	☐ Cancer	☐ Kidney/Renal problems
☐ Heart disease	☐ Fever	☐ Arthritis/Joint/Bone Disease
☐ High cholesterol	☐ Weight loss	☐ Acne/Skin problems
☐ Allergies	☐ Ear/nose/throat	☐ Stroke/Neurological Problems
☐ HIV	☐ Asthma/Bronchitis	☐ Headaches
☐ Thyroid Disease	☐ Ulcers/Gastritis	☐ Currently Pregnant (Females)
☐ Other: _____		☐ Nursing (Females)

Medications (including BCP, OTC meds, & any eye drops): _____

_____

Allergies (list allergies to medication or substances): _____

SOCIAL HISTORY

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Deceased Spouse

Employment Status: ☐ Employed ☐ Self-Employed ☐ Homemaker ☐ Retired ☐ Unemployed
☐ Medical Disability ☐ Student ☐ Child

Hobbies: _____

Do you use tobacco products? ☐ Yes ☐ No If yes, type and how often? _____

Do you drink alcohol? ☐ Yes ☐ No If yes, type and how often? _____

Do you use illegal drugs? ☐ Yes ☐ No If yes, type and how often? _____

FAMILY HISTORY

☐ Diabetes	☐ Arthritis	☐ Macular Degeneration
☐ Heart Disease	☐ Glaucoma	☐ Retinal Detachment
☐ Thyroid Disease	☐ Cataracts	☐ Other: _____

HIPAA PRIVACY NOTICE

I acknowledge that I have been shown the HIPAA – Notice of Privacy Practices. I understand that I may also obtain a copy of the Notice, if I request it.

Please list anyone whom you would like to authorize us to disclose information regarding your Protected Health Information, including billing information (you do not need to list any of your doctors).

	Name	**Relationship**	**Phone**
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

Patient's name (print):_____

Signature: _____ Date: _____
(Patient or Guardian)

ASSIGNMENTS & RELEASE/ SERVICES & MATERIALS RENDERED:

I hereby authorize my insurance benefits to be paid directly to the physician and understand that I am financially responsible for non-covered services. I authorize the physician to release information required to process this claim. I also acknowledge that if I am not using insurance benefits, payment is expected in full at time of services and/or materials rendered.

Signature of responsible party: _____

RETINAL IMAGING

Optomap is a state of the art retinal imager that allows up to a 200 degree view inside the eye. This innovative device allows us to capture a digital image of your retina, therefore allowing the doctor to evaluate your eye health without getting dilated. The retina is the only part of the body that the blood vessels can be viewed clearly without surgery or ultrasound. Conditions that may be detected in retinal photography include:

Birth Defects and Childhood Eyes Disease
High Blood Pressure
Diabetes
Macular Degeneration
Glaucoma
Optic Nerve Disease
Malignant and Benign Tumors
and more

Early detection is crucial!

We recommend Optomap for ALL of our patients annually. The cost for this testing is only **$44** and is typically not covered by insurance.

____ I elect to have Optomap (digital retinal imaging) for $44.

____ I decline to have an internal examination of the eye by retinal imaging.

Patient Name (Print) _____

Patient (or Guardian) Signature _____ Date: _____

All exam fees are non-refundable
Insurances are only accepted at time of service