Sarah Solomons, OD
312 S Ave D, Burkburnett, TX 76354
Phone: (940) 569-1177 Fax: (940) 400-0203

Today's Date:____/____/_____

Patient Information

First Name: _____ **MI:**____ **Last Name:**_____ **Preferred Name:**_____
Mailing Address:_____ **City:**_____ **State:**_____ **Zip:**_____
Date of Birth:_____/_____/_____ **SSN:**_____-_____-_____ **Gender:** □ Male □ Female □ Other
Language: □ English □ Spanish Other_____
Race: □ American Indian or Alaska Native □ Asian □ Black or African American □Native Hawaiian or other Pacific Islander □ White
Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino
Phone:_____-_____-_____ **Work:** _____-_____-_____ **Cell:** _____-_____-_____
Preferred Method of Contact: □ Home Phone □ Work Phone □ Cell Phone □ E-mail
E-mail:_____
Marital Status: □ Single □ Married □ Divorced □ Other
Employment: □ Full Time Student □ Part Time Student □ Employed □ Retired □ Other **School:** _____
Employer:_____ **Occupation:**_____ **Employer Phone:**_____-_____-_____
Spouse/Guardian Name:_____**DOB:**____/____/_____
Spouse/Guardian Employer:_____**SSN:**_____-_____-_____
Emergency Contact:_____**Relationship:**_____**Phone:**_____-_____-_____
Have we seen other members of your family? □ Yes □ No **If yes, whom?**_____

How did you hear about us?
□ Internet Search □ Facebook □ Insurance □ Other:_____□ Patient:_____

Please have your HEALTH Insurance card and a photo ID available.

Insurance Information

Name of MEDICAL Insurance: _____ **Name of VISION Insurance:**_____
Name of Insurance Subscriber:_____ **Relationship to Patient:**_____
SSN of Insurance Subscriber:_____-____-_____ **DOB of Insurance Subscriber:**____/____/_____
Employer of Insurance Subscriber_____ **Employer Phone of Insurance Subscriber:**_____-_____-_____

Health Information

Family MEDICAL Doctor_____ **Last MEDICAL Exam:** _____
Last EYE Doctor:_____ **Last EYE Exam:** _____
Other Doctor Who Referred You to Our Office:_____
Height:_____feet _____ inches **Weight:** _____ pounds
List ALL medications you are currently taking (including Rx and OTC):_____
_____
_____
List all EYE medications you are currently taking (including Rx and OTC):_____
_____
List any EYE problems you have had: (crossed or lazy eyes, drooping eyelid, prominent eyes, retinal disease, eye infections/ injuries)
_____
List all major injuries, surgeries &/or hospitalizations: _____
_____
Do you wear GLASSES? □ Yes □ No If yes, how old are your current lenses?_____
Do you wear CONTACT LENSES? □ Yes □No If yes, answer the following questions:
Type: □ Rigid □ Soft □ Toric/Astigmatism □ Monovision □ Multifocal
How old are your current lenses?_____ How often do you dispose of your lenses?_____

Communication Authorization and Release of Information

Patient Name:_____ **DOB:**____/____/_____

Do we have permission to contact you to discuss appointments, billing, merchandise, health issues, etc:

1. Leave a message on your answering machine or voicemail? □ Yes □ No
2. Contact you at work? □ Yes □ No
3. Send a text message? □ Yes □ No
4. Send an e-mail? □ Yes □ No
5. Discuss your medical information with anyone, besides yourself? □ Yes □ No

If yes, whom?_____

Acknowledgment of Review of Notice of Privacy Practices

I have been given the opportunity to review this office's Notice of Privacy Practices, which explain how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Signature of Patient or Representative: _____Date: ____/____/_____

Office Policies and Assignment of Benefits

Please Initial

_____ I understand *Medicare and many private insurances* **DO NOT** cover **REFRACTIONS** (prescription for eyeglasses). If my policy does not cover this, there will be a **$36.00 charge** due at the time of service or billed to me if my insurance fails to pay.

_____ I understand this office performs comprehensive, medical-based eye exams. **If my insurance requires a referral or I am covered for a ROUTINE / WELLNESS eye exam, it is my responsibility to notify this office *prior* to my exam**. A **ROUTINE / WELLNESS** eye exam **does not include** treatment or discussion of any acute illness/problem or management of a chronic condition (red eyes, dry eyes, headaches, diabetes, glaucoma, cataracts, macular degeneration, etc) If these issues are addressed, including medications or refills, during a **ROUTINE / WELLNESS** visit, *you will be responsible for payment* of any copay or deductible required by your **MEDICAL** insurance, ***VISION PLANS DO NOT COVER COMPLAINTS; THEY ARE FOR ROUTINE / WELLNESS EXAMS ONLY.*** I understand insurance claims **CANNOT** be changed or resubmitted once they have been filed.

_____ I hereby authorize the release of any medical information necessary to process my insurance claim and assign to the doctor all payments from *Medicare and any other insurance carriers* for materials and services rendered. I understand and agree to the above conditions**. I understand that I am responsible for my account balance if my insurance denies due to termination, deductible or other reasons.**

CONTACT LENS EVALUATIONS

_____ I understand that the charge for evaluating and determining my suitability for contact lens wear is **NOT** included in the comprehensive exam fee or the refraction fee. I understand that **most insurance companies DO NOT cover the contact lens evaluation** and I am responsible for this fee. I understand that this is a professional service fee & **will not be refunded** if I choose to discontinue contact lens wear.

Signature of Patient or Representative: _____Date: ____/____/_____

Are you ***currently*** or have you ***ever*** had any problems in the following areas?
Also, please indicate if there is any ***family history*** of any of the following conditions.

Ocular History	**Yes**	**No**	**Family**			**Yes**	**No**
Cataract	**Y**	**N**	**Y**	**N**	Blurred Vision	**Y**	**N**
Macular Degeneration	**Y**	**N**	**Y**	**N**	Eyestrain	**Y**	**N**
Glaucoma or Glaucoma Suspect	**Y**	**N**	**Y**	**N**	Eye pain	**Y**	**N**
Diabetes	**Y**	**N**	**Y**	**N**	Severe sensitivity to lights	**Y**	**N**
Diabetic Retinopathy	**Y**	**N**	**Y**	**N**	Headache	**Y**	**N**
Dry Eye	**Y**	**N**			Poor night vision	**Y**	**N**
Eye Infection, inflammation, or allergy	**Y**	**N**			Bothersome night glare	**Y**	**N**
Floaters and/or flashes of light	**Y**	**N**			Double vision	**Y**	**N**
Iritis or Uveitis	**Y**	**N**			Total loss of vision	**Y**	**N**
Retina defects or degenerations	**Y**	**N**	**Y**	**N**	Eye Surgery	**Y**	**N**
Redness	**Y**	**N**			Eye Patching	**Y**	**N**
Burning	**Y**	**N**			Strabismus/Amblyopia	**Y**	**N**
Itching	**Y**	**N**			Keratoconus	**Y**	**N**
Tearing (Watery Eyes)	**Y**	**N**			Eye Injury	**Y**	**N**
Eye Discharge	**Y**	**N**			Nystagmus	**Y**	**N**

List any other Eye Conditions or Concerns:

Review of Systems	***Please circle*** if you currently or ever had problems in the following areas?		
Constitution	Developmental Disabilities? Cancer? Fatigue Syndrome?	Other	None
Ear, Nose, Throat	Hearing Loss? Sinusitis? Dry Mouth? Laryngitis?	Other	None
Neurological	Multiple Sclerosis? Epilepsy? Cerebral Palsy? Tumor? Stroke/CVA? Migraine? Autism Spectrum Disorder?	Other	None
Psychiatric	Depression? ADHD? Anxiety Disorder? Bipolar Disorder?	Other	None
Cardiovascular	Hypertension (High Blood Pressure)? Stroke/CVA? Heart Disease? Vascular Disease? Congestive Heart Failure?	Other	None
Respiratory	Cigarette Smoker? Asthma? Bronchitis? Emphysema? Chronic Obstruction? Sleep Apnea?	Other	None
Gastrointestinal	Crohn's? Colitis? Ulcer? Acid Reflux? Celiac Disease?	Other	None
Genitourinary	Kidney Disease? Prostate disease/cancer? Benign Prostate Hypertrophy(BPH)? Herpes?Chlamydia? Pregnant? Nursing?	Other	None
Musculoskeletal	Arthritis? Osteoarthritis? Fibromyalgia? Muscular Dystrophy? Ankylosing Spondylitis? Osteoporosis? Gout?	Other	None
Integumentary	Eczema? Rosacea? Psoriasis? Herpes Simplex/Cold Sores? Herpes Zoster/Shingles?	Other	None
Endocrine	Type 2 Diabetes? Type 1 Diabetes? Thyroid Dysfunction? Hormonal Dysfunction?	Other	None
Hematologic/Lymphatic	Anemia? Large-volume blood loss? Ulcer? Hypercholesteremia?	Other	None
Allergic/Immunologic	Drug Allergies? Environmental Allergies? Rheumatoid Arthritis? Lupus? Sjogren's Syndrome?	Other	None

List Allergies:

List any other Health Conditions or Concerns:

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Social History	
Drinking	Amount
Tobacco Use	Cigarettes? Cigars? Pipe? E-cig? Other? Smokeless Tobacco?
Smoking Status	Current Every Day Smoker? Current Some Day Smoker? Former Smoker? Heavy Tobacco Smoker? Light Tobacco Smoker? Never Smoker? Smoker, current status unknown? Unknown if ever smoked?
Hobbies/Activities	
Occupation	
School & Grade	

Was today's reason for visit due to an accident? Employment, Auto or Other If so, date of accident_____

Is there any other information you would like us to know?

iWellness & optomap Retinal Imaging

Digital retinal screening photos using ***ultra-widefield digital scanning ophthalmoscopy*** allows our doctor to evaluate your eyes for the earliest signs of conditions such as glaucoma, macular degeneration, diabetic and/or hypertensive retinopathy, retinal holes, retinal detachments, and many more.

These diagnostic screening photos also allow for permanent documentation of your eye health and to establish a baseline to observe any changes that may occur over time.

In most cases, routine imaging is not covered by insurance and are offered at a fee of $29. ***Dilation may still be necessary based on your specific conditions or concerns.***

The doctor will view these images with you, providing the current health of your eyes and disease management if applicable.

_____**YES I WANT** the iWellness & optomap Retinal Screenings for $29.00

_____**NO I DO NOT** want the iWellness & optomap Retinal Screenings

Patient Name_____

Patient/Guardian Signature_____ **Date:**_____

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