Dr. Jack Rountree, Therapeutic Optometrist, Glaucoma Specialist

Patient Information

Today's Date ____________________________

Last ____________________________________

First____________________MI__Title________

Street_________________________________

City______________________State________

Zip Code________________________________

Home Phone_____________________________

Daytime Phone___________________________

Date of Birth___________________Age______

What is the Major Purpose of this visit?

____

Any problems with your current glasses or contacts?

____

____

Current Ht:_______ Weight:_________

Please list you current medications.

____

____

Allergies to medications

____

History of seizures?

____

Are you pregnant or nursing?

____

Insurance Information

Please note that *Eye Exam* coverage does not automatically cover the contact lens fitting fee. Fitting fee is an annual reoccurring fee. Contact lens fitting is good for 3 visits or 60 days, whichever occurs first. X_______ initial here.

***Vision Insurance*____**

Primary Name_____________________________________

Primary Member ID_________________________________

Subscriber D.O.B.__________________________________

***Primary Medical Insurance*______________________________**

Primary Name_____________________________________

Primary Member ID_________________________________

Primary D.O.B._____________________________________

Patient Medical History

*****Please note*****

We do retinal photos on everyone. Because many diseases and disorders can be identified through this test, it is an essential part of your medical eye exam every year. X_________ initial here.

Date of Last Eye Exam_______________________________

Name of Eye Doctor_________________________________

Name of Family Physician____________________________

Date of Last Physical Check-up ________________________

Please list any surgeries you have had since last eye exam (Eye, Body).

____

____

Authorization and Consent

I certify that I have read and understand the **Patient Information Sheet** (dated __________________) to the best of my knowledge. The questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the eye doctor to release any information including the diagnosis and the records of any treatment of examination rendered to my child or me during the period of such eye care to third party payers and/or health practitioners. I further authorize any holder of any medical information about me to release to any medical benefits provider information necessary to determine my eligibility and/or benefits. I authorize and request my insurance company to pay directly to the eye doctor or ophthalmic group insurance benefits otherwise payable to me. I understand that my eye care insurance carrier may pay less than the actual bill for services; therefore, I agree to be responsible for payment of the balance of all services rendered on my behalf or that of my dependants. Upon future visits to this practice, I will review the **Patient Information Sheet,** make all necessary changes and sign, and date a new Authorization. I have the right to revoke this Authorization at any time by providing the practice with a signed written request. Until such a request is received, the Authorization will be in effect for six years from the date of the most recent signed Authorization. I have the right to expect my personal health information to be protected as outlined in the Notice of Privacy Practices below. The terms of the notice may change. If I desire, a copy of the new Notice will be provided to me by requesting one in writing from this practice. I can request to have my consent to use my Protected Health Information revoked at any time with a signed written request to this practice.

X ______________________________________ _______________

SIGNATURE OF PATIENT (Or parent or guardian of a minor) DATE

Dilation of the Pupils

Dilation of pupils is included as a part of your full annual eye exam. If you have a condition such as diabetes, high blood pressure, cataracts, headaches, high myopia (nearsightedness), symptoms of flashes of lights of floaters, glaucoma or a family history of glaucoma, dilation is even more an important part of your eye exam. By dilating your pupils, many diseases both in your eyes and body can be detected long before any signs or symptoms arise. Dilation involves placing drops in your eyes to enlarge the pupil size.

When an eye is dilated, we are able to get a much broader and fuller view of the inside of the eye. This aids the doctor in determining if diseases (such as macular degeneration, glaucoma and tumors) are present, if there is damage to the retina (such as holes and tears) and also in the evaluation of cataracts.

With dilation of the eyes you may experience the following effects:

- **Increased sensitivity to light**
- **A slight blurring of your distance vision**
- **Inability to focus up close**

These effects may last from 1 to 4 hours.

Please check one of the following options and sign below:

___ I do consent to having my eyes dilated.

___ I do not want to be dilated, but understand the importance of the dilation. I release Dr. Jack Rountree from any liabilities related to the failure to diagnose or treat any eye condition due to the lack of diagnostic information which could have been obtained by the test.

Patient Signature____________________________________ Date__________________________