PATIENT HISTORY

Date_____Name_____Date of Birth_____Age_____**Cell ph**_____

Address_____City/State/Zip_____Home ph_____

Email_____May we contact you by text/email? □Yes □No Parent/guardian_____

Family Dr_____Occupation_____ _Hobbies/Sports/Visual Needs_____

Who may we thank for referring you to us?_____When/where was your last eye exam?_____

Reason for Visit Today_____

Currently wear: □ Glasses □ Contact lenses, if yes, brand_____ Are you interested in contact lenses? □ No □ Yes

Current Eye Symptoms:

□ Distance vision blurred □ Double vision □ Dry eyes □ None, routine exam
□ Near vision blurred □ Red eyes □ Itchy eyes □ Other/comments_____
□ Eyestrain □ Burning eyes □ Watery eyes

Eye History: (check those that apply to YOU)

□ Glaucoma □ Cataracts □ Macular degeneration □ Eye injury □ Eye surgery □ Other_____

Personal Medical History: (check those that apply to YOU)

□ Psychiatric disorder □ Heart/cardiovascular disease □ Diabetes
□ Arthritis/bone problem □ High Blood Pressure □ Neurological (MS, migraines): type_____
□ Allergies □ Blood problem: type_____ □ Breathing/lung problem: type_____
□ Thyroid disease □ Skin disease: type_____ □ Other_____

Family History: (check those that apply to your blood relatives)

□ Diabetes □ Glaucoma □ Retinal detachment □ Macular degeneration □ Other eye disease_____

Please list any medications you are taking:_____
_____

Are you allergic to any medications? □ No □ Yes:_____

Do you smoke? □ No □ Yes

Are you pregnant? □ No □ Yes

HIPAA NOTICE

I have seen (on the wall) or been offered a copy of the HIPAA Privacy Notice.

Sign:_____

CONSENT TO BILL INSURANCE

I authorize this office to bill and collect payment for services rendered to me and to use a photocopy of my signature. I understand I am financially responsible for all non-covered services.

Sign:_____

EYE DILATION

The doctor may need to give you some mild eye drops to allow him/her to check for eye diseases and prescribe the most accurate prescription. The eye drops temporarily make you more light sensitive and make your near vision blurry. Distance vision is not usually affected. Sunglasses will be provided. **Please initial:**

_____ It is OK to dilate my eyes. _____ I do not want my eyes dilated. Sign:_____

FOR CONTACT LENS WEARERS

Contact lenses are medical devices available by prescription only. As with any drug or device, contact lens wear is not without risk. There is a small but significant risk of serious complications associated with contact lens wear. If you experience any pain, redness, discharge, loss of vision or light sensitivity, remove your contacts immediately and call our office or another eye specialist.

Sign:_____