WELCOME TO GRAND EYE CARE

RICHMOND, TX

PATIENT INFORMATION

DR. / MR. / MRS. / MS. (CIRCLE ONE)

LAST:	FIRST:	MI:	DATE OF BIRTH:	AGE:

MAILING ADDRESS:	CITY:	STATE:	ZIP CODE:

CELL PHONE:	HOME PHONE:	OCCUPATION:

EMAIL:	EMPLOYER/SCHOOL NAME:

OCULAR HISTORY

Date of last eye exam:	Name of last eye doctor:

REASON FOR VISIT: ☐ Poor distance vision ☐ Poor near vision

☐Other:_____

Do you wear: ☐ Glasses ☐ Contact lenses **Are you interested in contact lenses?** ☐ Yes ☐ No

Are you having any problems with your: **Glasses?** ☐ Yes ☐ No **Contacts?** ☐ Yes ☐ No

Are you interested in Refractive Surgery? ☐ Yes ☐ No

Check off any eye conditions that apply to you:

☐ Flashes ☐ Crossed/Lazy Eye ☐ Dry Eye ☐ Double Vision ☐ Cataract ☐ Floaters
☐ Glaucoma ☐ Retinal Disease ☐ Eye Injury ☐ Eye Surgery ☐ Eye Disease

☐Other:_____

MEDICAL HISTORY

Date of last Physical Exam:	Name of Primary Care Physician:

List any medications (including eye drops) that you are currently taking:

List any allergies to medications, food, or other substances:

Check off any medical conditions that applys to YOU:

General/Constitutional: ☐ Fever ☐ Chills ☐ Weight Loss ☐ Weight Gain ☐ Insomnia ☐ Fatigue
Skin: ☐ Eczema ☐ Rashes ☐ Dryness ☐ Itching ☐ Hair Changes ☐ Nail Changes
Neurological: ☐ Headaches ☐ Migraines ☐ Seizures
Endocrine: ☐ Diabetes ☐ Thyroid ☐ Other Glands: _____
Ear, Nose, Throat: ☐ Allergies ☐ Sinus ☐ Cough ☐ Dry Mouth ☐ Sore Throat
Respiratory: ☐ Asthma ☐ Bronchitis ☐ Emphysema ☐ COPD
Cardiovascular: ☐ Heart Disease ☐ High Cholesterol ☐ High Blood Pressure
Gastrointestinal: ☐ Diarrhea ☐ Constipation ☐ Heartburn ☐ Swallowing Difficulties ☐ Change in Appetite
Genitourinary: ☐ Frequent Urination ☐ Urinary Tract Infection ☐ Hernia ☐ Kidney Stones
Musculoskeletal: ☐ Rheumatoid Arthritis ☐ Muscle Pain ☐ Joint Pain
Lymphatic/Hematological: ☐ Anemia ☐ Bleeding Problems ☐ Ease of Bruising
Psychiatric: ☐ Agitated ☐ Memory Loss ☐ Depression ☐ Mood Swings ☐ Suicidal Thoughts
Allergic/Immunologic: ☐ Food Allergies ☐ Pollen / Dust Allergies

Other: _____

FAMILY HISTORY

☐ **Adopted**

Check off any medical conditions that apply to your FAMILY:

Diabetes:	☐ Grandparents	☐ Parents	☐ Siblings	☐ Other
High Blood Pressure:	☐ Grandparents	☐ Parents	☐ Siblings	☐ Other
Heart Disease:	☐ Grandparents	☐ Parents	☐ Siblings	☐ Other
Cancer:	☐ Grandparents	☐ Parents	☐ Siblings	☐ Other
High Cholesterol:	☐ Grandparents	☐ Parents	☐ Siblings	☐ Other
Thyroid:	☐ Grandparents	☐ Parents	☐ Siblings	☐ Other
Kidney:	☐ Grandparents	☐ Parents	☐ Siblings	☐ Other
Arthritis:	☐ Grandparents	☐ Parents	☐ Siblings	☐ Other

□ Other: _____

_____

Check off any ocular conditions that apply to your FAMILY:

Blindness:	☐ Grandparents	☐ Parents	☐ Siblings	☐ Other
Cataract:	☐ Grandparents	☐ Parents	☐ Siblings	☐ Other
Crossed/Lazy Eye:	☐ Grandparents	☐ Parents	☐ Siblings	☐ Other
Glaucoma:	☐ Grandparents	☐ Parents	☐ Siblings	☐ Other
Macular Degeneration:	☐ Grandparents	☐ Parents	☐ Siblings	☐ Other
Retinal Disease:	☐ Grandparents	☐ Parents	☐ Siblings	☐ Other
Eye Injury:	☐ Grandparents	☐ Parents	☐ Siblings	☐ Other
Eye Surgery:	☐ Grandparents	☐ Parents	☐ Siblings	☐ Other
Other Eye Disease:	☐ Grandparents	☐ Parents	☐ Siblings	☐ Other

SOCIAL HISTORY

Hobbies: _____

Do you drive?

☐ No ☐ Yes, When do you have difficulty driving? _____

Drink alcohol?

☐ No ☐ Yes, Type _____ Amount _____ How Often?_____

Use illegal drugs?

☐ No ☐ Yes, Type _____ Amount _____ How Often?_____

Use tobacco products?

☐ No ☐ Yes, Type _____ Amount _____ How Often?_____

Have you ever been exposed to or infected with:

☐ Never been exposed to or infected ☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis ☐ STD

Are you pregnant and/or nursing?

☐ No ☐ Yes

AT GRAND EYE CARE, WE PRIDE OURSELVES ON PROVIDING OUR PATIENTS WITH THE BEST POSSIBLE STANDARD OF CARE.
WE ARE COMMITED TO EARLY DETECTION AND PREVENTION OF EYE DISEASES.
WE STRONGLY RECOMMEND COMPREHENSIVE OCULAR HEALTH ANALYSIS ONCE PER YEAR.

DILATED FUNDUS EXAM enables us to provide a more thorough ocular health analysis. With dilated pupils, we get a better view inside the eye allowing earlier detection of signs or changes from ocular pathologies. A Dilated Fundus Exam is essential for diabetics, hypertensives, high myopes, and/or patients with any history of other related ocular diseases. The side effects are blurred near vision and light sensitivity. In some individuals, the distance may also be blurred.

Dilated Fundus Exam is included in the Comprehensive Eye Exam

☐ **YES, I DO WANT THE DILATED FUNDUS EXAM** ☐ I do **NOT** want the Dilated Fundus Exam

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RETINAL IMAGING provides the doctor with a view of your retina in a single capture. The captured retinal image becomes a permanent record for your medical file, enabling the doctor to make important comparisons if potential vision threatening conditions present themselves now or at future examination.

*The Retinal Imaging Scan is **not** covered by your vision insurance plan. There is a **$44.00 fee***

☐ **YES, I DO WANT THE RETINAL IMAGING SCAN** ☐ I do **NOT** want the Retinal Imaging Scan

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VISUAL FIELD ANALYSIS is a highly advanced computerized instrument that provides us a more thorough analysis of your field of vision. **VISUAL FIELD SCREENING** can assist us in early detection of glaucoma, retinal problems, some neurological diseases and may diagnose the cause of headaches.

*The Visual Field Analysis is **not** covered by your vision insurance plan. There is **$28.00 fee***

☐ **YES, I DO WANT THE VISUAL FIELD ANALYSIS** ☐ I do **NOT** want the Visual Field Analysis

I understand that without these tests, certain eye diseases and conditions may not be discovered. I agree to assume all risk associated with refusing these test, indemnify, hold harmless, and release Grand Eye Care, its employees and optometrists, from any and all claims or liability whatsoever related to failure to diagnose and/or treat any eye conditions due to lack of diagnostic information which could have been obtained by these tests.

OFFICE POLICY

- **All visits are due and payable at the time of service. All insurance must be verified and authorized in advance.**
- **Fees paid for any services and materials are NON-REFUNDABLE.**
- **There will be no fee for follow up visits on glasses or contact lens fitting within 30 days of the initial comprehensive exam. Follow-ups on glasses or contact lenses past 30 days require the usual and customary fee.**

_____

Patient or Patient's Legal Representative's Signature **Date**

HIPAA PRIVACY ACKNOWLEDGMENT OF RECEIPT OF NOTICE PRIVACY PRACTICES

I, _____ ("Patient" or "Patient's legal representative"), have been
(Please Print full legal name)
presented with the Notice of Privacy Policy (the "Policy") of Grand Eye Care (the "Provider") and have been offered a copy of such policy to keep for my records.

_____ I hereby **acknowledge** that I have been provided with a laminated copy of the Policy.
(Please Initial) (A copy of the policy will be provided upon request)

_____ I hereby **refuse** to acknowledge receipt of the Policy. I understand that even though I may
(Please Initial) refuse to sign this acknowledgement, Provider may still provide treatment to me.

_____

Patient or Patient's Legal Representative's Signature **Date**

INSURANCE INFORMATION

Vision Insurance	**Medical Insurance**	
Primary Name (on card)	**Primay Date of Birth**	**Insurance ID or Primary Social Security Number**
Primary Employer	**Relationship to Primary**	

INSURANCE SIGNATURE ON FILE

I certify that the information given by me in authorizing insurance benefits is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and I authorize payment of these benefits directly to the doctor on my behalf for any service furnished. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents, any information needed to determine these benefits payable to related services. **I understand all insurance benefits must be verified and authorized prior to services being rendered and materials being ordered in order to utilize the insurance benefit.**

I understand I am responsible for the balance of fees not paid by my insurance.

_____

Patient or Patient's Legal Representative's Signature **Date**