NEW PATIENT HISTORY

Name:_____ Today's Date:_____

Address:_____City:_____State:_____Zip:_____

Cell Phone:_____Home Phone:_____

Employer:_____Occupation:_____

Date of Birth:_____Age:____ Sex: M___ F___ E-mail:_____

VISUAL AND MEDICAL HISTORY

Reason for today's exam: Glasses___Contacts___ Other____Explain_____

List medications you are currently taking_____

_____

Have you been seen at this office before? Yes___ No____ Do you have vision insurance? Yes____No _____ If yes, what is your insurance provider?_____

Please check any condition that applies to yourself or any members of your immediate family:

	Self	*Family*		*Self*	*Family*		*Self*	*Family*
Diabetes	___	___	Thyroid Problems	___	___	Retinal Detachment	___	___
High Blood Pressure	___	___	Headaches	___	___	Double Vision	___	___
Heart Problems	___	___	Head Injury	___	___	Lazy Eye	___	___
High Cholesterol	___	___	Glaucoma	___	___	Eye Surgery	___	___
Kidney Problems	___	___	Macular Degeneration	___	___	Eye Injury/Infection	___	___
Liver Problems	___	___	Cataracts	___	___	Diabetic Retinopathy	___	___

Optomap- The doctor highly recommends the optomap for **ALL PATIENTS** because it offers the following benefits:

- is fast,easy comfortable and has **no side effects**
- enables the doctor to better **monitor** your eye health annually
- gives a more **complete view** of the inside of your eye (**the retina**) than previously possible without dilation

The fee for this **extended exam** is only **$55** **NOT COVERED BY INSURANCE** Yes, I accept _____ No _____

The Visual Field Test- The visual field test is in **addition to the routine exam**.
The test evaluates for any areas of weakness or blind spots. It is also useful for detecting the **causes of headaches** and other eye disorders. It has **no side effects**.

The fee for the visual field test is **$50 NOT COVERED BY INSURANCE** Yes, I accept _____ No _____

Optovue Digital Wellness Test - The Optovue test is in **addition to the routine eye exam. No side effects.**
The doctor highly recommends this screening test for **early detection** of **macular degeneration** and **glaucoma** in everyone.

The fee for this advanced test is **$50** **NOT COVERED BY INSURANCE** Yes, I accept _____ No_____

_____

I acknowledge that I have read and/or received a copy of Dr. Riegler's *Notice of Privacy Practices.*

Patient or Guardian Signature_____.

I consent to treatment at the office of Bastrop Eye care. I authorize any holder of medical information about me to release that information to any agency necessary to determine benefits payable. Signature _____