Precision eye care & optical

New Patient Information

Name: _____ Nickname: _____ DOB: _____ Date: _____

Address: _____ Apt/Lot#: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work: _____ Cell: _____

Email Address: _____ SSN: _____

Communication Preference: ☐ Phone ☐ Email Can we send you text reminders/notifications? ☐ Yes ☐ No

Preferred Language: _____ Ethnicity: _____ Height: _____ Weight: _____

Do you smoke? ☐ Y ☐ N ☐ Former If Y, how much? _____ If Former, how long ago? _____

Marital Status: _____ Employer: _____ Occupation: _____

In case of an emergency, please contact:

Name: _____ Phone: _____ Relation: _____

List ALL Current Medications Including Prescriptions, Over the Counter, Vitamins or Eye Drops:

_____

_____

☐ I **do not** take any medications ☐ I **will present** my medication list (that the practice can copy)

Are you allergic to any Medications? ☐ Yes ☐ No If Yes, please list: _____

Do you wear contact lenses? ☐ Yes ☐ No If Yes, what type? _____

Do you suffer from any of the below on a regular basis without glasses or contacts?

- ☐ Blurred Vision
- ☐ Floaters in Eyes
- ☐ Flashes of Light
- ☐ Burning Eyes
- ☐ Itching Eyes
- ☐ Watery Eyes
- ☐ Dry Eye
- ☐ Eye Strain or Pain
- ☐ Headaches

How many years since your last eye exam?

_____

Check the box if you or a family member had any of the following:

Self	Family		Family Relation
☐	☐	Diabetes	_____
☐	☐	High Blood Pressure	_____
☐	☐	Cardiac Trouble	_____
☐	☐	Breathing/Asthma	_____
☐	☐	Cancer	_____
☐	☐	Allergies	_____
☐	☐	Thyroid Disorder	_____
☐	☐	Macular Degen	_____
☐	☐	Glaucoma	_____
☐	☐	Lazy/crossed Eye	_____
☐	☐	Cataracts	_____

List any eye surgeries you have had: _____

Last Eye Doctor Visited: _____ Primary Care Doctor: _____

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Eye Health Assessment: Please choose from one of the 5 Options at the bottom of the page.

Evaluating the retina and optic nerve is important because our doctors are able to detect:

- Physical changes of the eyes: glaucoma, macular degeneration, retinal detachments, etc.
- Systemic diseases of the body: diabetes, hypertension, blood disorders, cancer, etc.

Dilation of Pupils

If you have Diabetes, Macular Degeneration, Retina conditions, Glaucoma, High Nearsightedness (>-6.00 D), or Floaters, then our doctors strongly recommend dilation every year.

Dilation allows our doctors to thoroughly evaluate the health inside the eye and is sometimes required to accurately determine the glasses prescription. These drops cause blurry vision for near work and sensitivity to light that last 3 to 5 hours. We can provide disposable sunglasses for you. Although most people are fine to drive after being dilated, some patients feel more comfortable having a driver available.

Optomap: Retinal Scan ($45)

Our doctors can show you the inside of your eyes. These photos will remain in your permanent record for future reference. Insurance does not cover Optomap. It is generally not recommended for young children.

There is no blurry vision or light sensitivity, and it takes 3 minutes to complete. Sometimes Optomap reveals a problem that will ALSO require dilation for further evaluation.

Note: Optomap is an excellent diagnostic tool, but dilation is still recommended every 2 to 3 years.

Macula Scan ($45)

The macula is the very center part of your vision in the retina. This screening test provides the doctor with a cross-section image of the macula. It helps evaluate for macular degeneration and swelling. Patients who have a family history of macular degeneration are especially encouraged to consider this scan.

Choose one of the following:

- ☐ **Option 1 (Best)**: I **do** give permission for Pupil Dilation **and** Optomap **and** Macula Scan ($65)
- ☐ **Option 2**: I **do** give permission for Pupil Dilation **and** Optomap ($45)
- ☐ **Option 3**: I **do** give permission **only** for Pupil Dilation (no additional fee)
- ☐ **Option 4**: I **do** give permission **only** for Optomap ($45)
- ☐ **Option 5**: I **do not** give my permission to be dilated and I **do not** give my permission for Optomap or Macula Scan to be performed. I will not hold the doctor responsible or liable for any pathology not diagnosed as a result of this omission (Not recommended)

Patient or Parent Signature: _____ Date: _____