TODAY'S VISION

PATIENT REGISTRATION

Today's Date: / / /

PLEASE FILL OUT ALL BLANKS COMPLETELY

PATIENT INFORMATION

Last Name: First Name: Birth Date: Age:

Sex: ☐ M ☐ F Marital Status: ☐ Single ☐ Married ☐ Child ☐ Other:

Address: City/State/Zip:

Home Phone: Cell Phone: Work Phone:

SSN#: Email:

What would be the best number to reach you during the day: ☐ Cell ☐ Home ☐ Work ☐ Email ☐ Text Messaging

Occupation/Student: Employer/School:

Do you have a specialized driver's license? ☐ None ☐ Pilot ☐ Motorcycle ☐ Other:

Do you have any special vision requirements or restrictions for your job?

Emergency contact name: **Phone:**

Relationship to patient: ☐ **Spouse** ☐ **Parent/guardian** ☐ **Child** ☐ **Partner** ☐ **Other:**

Reason for today's visit (check all that applies): ☐ Exam ☐ Glasses ☐ Contact lens ☐ Emergency ☐ Other:

INSURANCE INFORMATION

PLEASE PROVIDE YOUR MEDICAL AND VISION INSURANCE CARDS

Your insurance company must authorize all coverage before testing can begin; otherwise the doctor will not be able to directly take your insurance. Patient may file on his/her own. Most insurance does not cover additional fees:

If you have one of the following medical/health/vision, please check the appropriate box(es):

- ☐ Aetna
- ☐ Avesis
- ☐ Blue Cross Blue Shield
- ☐ Blue Cross Blue Shield of TX
- ☐ Cigna
- ☐ Davis Vision
- ☐ Eyemed
- ☐ Humana
- ☐ Medicare
- ☐ Mesvision
- ☐ Optum Health
- ☐ No Insurance
- ☐ Safeguard
- ☐ Spectera/Optum Health
- ☐ Superior Vision
- ☐ Tricare
- ☐ Other:
- ☐ United Healthcare (UHC)
- ☐ Vision Benefits of America
- ☐ Vision Service Plan (VSP)

Are you the Primary on the account? ☐ Yes ☐ No Primary SSN#: - -

Primary Insured Name: Birth Date: Sex: ☐ M ☐ F

Additional Insurance Information:

EYE HEALTH HISTORY

When was your last eye exam?

Have you or a family member (parent or sibling) ever been diagnosed with or treated for:

Self	Family		Self	Family		Self	Family	
☐	☐	Blindness	☐	☐	Strabismus(crossed eyes)	☐	☐	Other Corneal Disease
☐	☐	Amblyopia (lazy eye)	☐	☐	Macular Degeneration	☐	☐	Retinal Detachment
☐	☐	Cataracts	☐	☐	Keratoconus	☐	☐	Retinal Disease
☐	☐	Glaucoma	☐	☐	Corneal Transplant	☐	☐	Dry eyes

Have you ever had any surgery, injury or laser treatments to the eye? ☐No ☐Yes (please describe below):

How are you currently managing your vision condition (check boxes that apply):

☐ Glasses – How old are your current glasses? ________________

☐ Contact Lenses -Types of contact lens worn in the past (Brand, Power, Size, Color): ________________

How many years have you worn your contacts? ________________

Do you sleep in your contacts? ☐ Yes ☐ No When did you last wear your contacts?________________

Updated on: 7/30/2019

PLEASE TURN OVER, AND COMPLETE THE BACK OF THIS FORM

PATIENT PREFERENCES

Rate your satisfaction of your current glasses/contacts: ☐ Extremely satisfied ☐ Very ☐ Somewhat ☐ Not very ☐ Not at all

What activities or hobbies would you enjoy more without the dependency of glasses/contacts? (e.g. swimming, skiing, movies, etc.)

How did you hear about us? ☐Internet ☐Mailer ☐Insurance ☐Walk in ☐Neighborhood ☐ Yelp ☐Google ☐ Other:

Will you use funds from an employer sponsored flexible spending plan to pay for today's services? ☐ Yes ☐ No

MEDICAL HISTORY

Have you or a family member (parent or sibling) ever been diagnosed with or treated for:

Self	Family		Self	Family	
☐	☐	Heart Disease	☐	☐	Hepatitis B or C
☐	☐	High Blood Pressure	☐	☐	HIV/AIDS
☐	☐	Stroke	☐	☐	Chron's Disease
☐	☐	High cholesterol	☐	☐	Osteoarthritis
☐	☐	Diabetes Type 1	☐	☐	Rheumatoid Arthritis
☐	☐	Diabetes Type 2	☐	☐	Currently Pregnant/Nursing
☐	☐	Thyroid Dysfunction	☐	☐	Kidney Disease
☐	☐	Migraines	☐	☐	Cancer, Type:
☐	☐	Multiple Sclerosis	☐	☐	Tumor, Type:
☐	☐	Asthma	☐		

OTHER:______________________________

Pharmacy Information

Name: ____________________________

Address/Location:

____

Phone: ___________________________

Fax: ______________________________

List all current medications/Eye drops you are using:

____

List all medications that you are ALLERGIC to:

____

Primary Care Doctor's Name:____

ADVANCED RETINAL EVALUATION (Inside/Back Part of Your Eyes)

Indicate your choice below

( ) **YES,** I want to have a Digital Retinal Evaluation to protect my Retinal Health. I understand that the Retinal Evaluation utilizes state of the art laser technology to capture a digital image of the retina **without dilation** of the pupil and there are no side effects. Our doctors recommend the tests:

____ Level 1— Retinal Phototography (for ages 1-29) **$30**

____ Level 2— Retinal Phototography + Optic Nerve / Macula Images (for ages 30-49) **$50**

____ Level 3— Retinal Phototography + Optic Nerve / Macula Images + Visual Field (for over 50 & Patients with health issues) ~~**$70**~~ $60

OR

( ) **YES**, I would like to protect My Retinal Health by having a Dilated Exam. I understand that dilating drops will enlarge the size of my pupil and that the side effects are light sensitivity and difficulty in focusing for reading. Your dilation may last up to 4 hours. The cost is $20.

OR

( ) **DECLINE**, I am not interested in having additional testing today. I understand , that by declining both Digital Retinal Evaluation and Dilation, I am limiting the ability of my physician to accurately determine the health of my eyes, And I agree to assume all risks associated with failure to diagnose my eye condition due to lack of information, which may have been provided by these tests.

( ) **DISCUSS** what option would be best for me with the doctor

____

Print Patient Name

______________________________ ______________ ____________

Signature of patient or Authorized Representative | Relationship to Patient | Date