Patient Authorization for Services

2NewAuthorizationforservices&MedHx20200729

Today's Date____/___/_____ ____ Date of Birth ____/___/______

Last name First name Middle name/Initial

CIRCLE ALL THAT APPLY BELOW

Are you interested in: Eyeglasses Sunglasses or Computer/Reading glasses?

Are you interested in Contact lenses? If so please know that a contact lens exam/fitting is additional, elective & usually not fully covered by vision care plans(insurance).
A contact lens exam/fitting ranges from $80 to $150 & more for specialty contact lenses.
If you are not sure, speak with the doctor about your contact lens requirements.

Permission to do contact lens exam. **Yes**, I want a Contact Lens Exam/Fitting or
No, and I will not receive a contact lens prescription.

Permission to Dilate: Yes, No or I want to discuss that with the doctor.

Permission for Retinal Photo: ($30.00 - Needed yearly if diabetes or have other medical diagnosis, otherwise every 2 years): Yes, No or I want to discuss that with the doctor.

Responsible Party Signature ________________________________ Date ___/___/____

MEDICAL HISTORY / CONDITIONS / MEDICATIONS Please Check All That Apply

[ ] Respiratory [ ] Asthma [ ] Cardiovascular [ ] High Blood Pressure [ ] High Cholesterol [ ] Endocrine

[ ] Diabetes [ ] Thyroid Disease [ ] Hormone Replacement [ ] Immunologic [ ] Allergies [ ] Skin Condition

[ ] Neurologic [ ] Psychiatric [ ] Musculoskeletal [ ] Ears, Nose, Mouth, Throat [ ] Gastrointestinal

[ ] Genitourinary [ ] Blood Disease / Lymphatic Disease [ ] Significant loss or gain of weight in the last year

[ ] Recurrent fever within last year [ ] other ____

Please List your specific diagnosis(s) from above: ____

____

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If Diabetic, Last Blood Sugar: __________ on ____/_____/______ and Last a1c: ________on___/____/________

List All Medications You Take: ____

____

____

List All Medications You are Allergic to: ____

List All EYE Disease, Injuries or Surgeries you have had: ____

____

List immediate family member and their medical conditions: ____

____

List immediate family member and their eye disease: ____

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