Welcome to Oaks Optometric Center

Full Name: _____ **Date of Birth:** ____/____/____ **Age:**____
First Last (Month/ Day/ Year)

Address: _____
Street CityState Zipcode

Phone: (____) _____ □ **Home** □ **Work** □ **Cell** **Occupation:**_____

Email Address: _____ **Gender:** □ Male □ Female

Personal Ocular History: *(please check all that apply)*

□ Blurred Distance Vision
□ Blurred Near Vision
□ Burning Eyes
□ Double Vision
□ Dry Eyes
□ Glaucoma
□ Headaches related to eyes
□ Itching Eyes
□ Light Sensitivity
□ Red Eyes
□ See Flashing Lights
□ Cataracts
□ See new floaters or spots
□ Temporary loss of vision
□ Watery Eyes
□ Macular Degeneration
□ Other _____
□ No Visual Complaints

Personal Medical History: *(please check all that apply)*

Constitution: □ Cancer □ Developmental Disabilities
Ear Nose Throat: □ Hearing Loss □ Sinusitis □ Dry Mouth
Neurological: □ Multiple Sclerosis □ Tumor □ Stroke/CVA □ Migraine □ Autism
Psychiatric: □ Depression □ Attention Deficit Disorder
Cardiovascular: □ Hypertension □ Stroke □ Heart Disease □ Congestive Heart Failure
Respiratory: □ Cigarette Smoker □ Asthma □ Bronchitis □ Emphysema

GI: □ Crohn's □ Colitis □ Ulcer □ Celiac Disease
GU: □ Kidney Disease □ STD-Hepetic/Chlamydia □ Herpes
Musc/Skel: □ Arthritis □ Ankylosing Spondylitis □ Gout
Integumentary: □ Rosacea □ Herpes Zoster/Shingles
Endocrine: □ Type 2 Diabetes □ Type 1 Diabetes □ Thyroid Condition
Hem/Lymph: □ Anemia □ Ulcer □ High Cholesterol
Alergy/Imm: □ Lupus □ Rheumatoid Arthritis □ Sjogren's Syndrome
Other _____
(please specify)

Medication(s): (Yes / No) Please list:_____

Drug or Other Allergies: (Yes/ No) Please list:_____

Do you drink and/ or smoke? (Yes/ No): Please list: _____

Family Medical History: Any family member(s) with the above conditions?
Please list: _____

If Female: Are you pregnant or nursing? (Yes / No)

When was your last eye exam? _____ **How did you hear about us?** _____

By signing below, I acknowledge that the above information is true and accurate.

SIGNATURE: _____ **DATE:** ____/____/____
(Parent or Guardian, if Minor)

(Please complete other side)

Welcome to Oaks Optometric Center

Acknowledgement of receipt of notice of Privacy Practices:

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct healthcare operations involving our office. The ***Notice of Privacy Practices*** you have been given describes these uses and disclosures in detail. **Initials ____**

Dilated Exam:

A dilated exam allows the doctor to examine the retina, helping to detect ocular and systemic diseases such as cataract, glaucoma, diabetes, and many other conditions. Side effects include blurred vision and sensitivity to light. The effects of the dilation can be intense for some people. The drops will usually wear off in 4-6 hours. We recommend you bring a driver and choose a day you can stay indoors. (The dilation portion of the exam can be re-scheduled within 1 month).

I understand that a condition with the potential for partial or total loss of vision may exist and without dilation it may go undetected.

□ **Yes, I want to dilate my eyes.**

□ **No, I do not want to have my eyes dilated.**

Retinal Photo:

The retinal photo during a routine eye exam is a valuable tool in documenting the retina, the back portion of the eye. The retinal camera takes a picture of the optic nerve head (the nerve connecting the eye to the brain), the macula (the area where you see detail), and the surrounding tissues and blood vessels. The photograph can help detect eye diseases like glaucoma, macular degeneration and diabetic retinopathy. Vision insurance does not cover this procedure and it would cost an additional $35 for the retinal image. Would you like to have a retinal photograph of your eyes for $35?

□ **Yes, I want a retinal photo for an additional $35**

□ **No, I decline the retinal photo**

By signing below, I acknowledge that I have read and fully understand the information above.

SIGNATURE: _____ **DATE:** ____/____/____

(Parent or Guardian, if Minor)

_____

(Relationship to patient, if Minor)

Insurance/Managed Care Acknowledgement:

I authorize Oaks Optometric Center to bill my insurance carrier(s) on my behalf. I understand that my insurance carrier(s) may not cover all services/materials and the authorization obtained at the time of service does not guarantee payment. I agree that if my employer, insurance carrier or plan sponsor denies payment of all or any portion of my claim, I will be financially responsible for all outstanding charges.

By signing below, I acknowledge that I have read and fully understand the information above.

SIGNATURE: _____ **DATE:** ____/____/____

(Parent or Guardian, if Minor)

_____

(Relationship to patient, if Minor)