

Welcome to Vision Today (Print the answers to all questions. Your information will remain confidential per HIPAA policy)

Name: _____ Nickname: _____
 First Middle Last

If minor, PARENT/GUARDIAN name: _____

Street Address: _____ Apt _____ City _____ State _____ Zip _____

Cell Phone: _____ Home Phone: _____ Email address: _____

Date of Birth: _____ Sex: Male Female SSN: _____

Occupation (or Grade): _____ Employer (or School): _____

Marital Status: Single Married Divorced Widowed Other

Who may we thank for telling you about our office? Facebook Google Yelp Insurance Previous Patient
 Walk By/Signage Referral from Friend or Family Member _____ Other _____

Race: African American Asian Caucasian Hispanic Native American Other

Preferred Language: English Other: _____

The name of your Medical Doctor is: _____ Phone: _____

AUTHORIZED USERS TO PATIENT'S RECORDS (EMERGENCY CONTACT):

Name: _____ Phone: _____ Relationship to Patient: _____

Name: _____ Phone: _____ Relationship to Patient: _____

Checking the Health of Your Eyes

The doctor strongly recommends all patients have the health of their eyes checked using our Retinal Screening Technology. This procedure involves capturing a digital picture and scan of the back of the eye, and detecting dysfunction in central and peripheral vision. This allows the doctor to evaluate for ocular diseases in more detail. We will also be able to track any changes that may occur through time. The screening is side effect free and may reduce exam time. It is NOT covered by any insurance and is an additional cost of \$39.

*Disclaimer: If any abnormalities are detected, the doctor may dilate the pupils for further investigation.

_____ I elect the Retinal Screening Technology to check the health of my eyes. (\$39)

The Florida Board of Optometry has established that a comprehensive eye examination for a new patient shall include a Dilated Fundus Exam. This procedure involves putting one or more drops in each eye that will dilate the pupils. The doctor will study the internal structures of your eye to ensure proper health. The drops administered will cause light sensitivity and some degree of blurred vision, especially near vision (effects can last up to 5 hours). Driving may be affected and should be done with extreme caution. Because your safety is of utmost importance to us, we prefer that you have someone with you to drive.

Personal Eye History

What is the reason for your visit today? **Glasses / Contacts / Both / Other:** _____

Do you have any of the following problems?

<input type="checkbox"/> Loss of Vision	<input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Eye Pain or Soreness	<input type="checkbox"/> Infection of Eye or Lid
<input type="checkbox"/> Double Vision	<input type="checkbox"/> Dryness	<input type="checkbox"/> Halos	<input type="checkbox"/> Redness
<input type="checkbox"/> Sandy/Gritty Feeling	<input type="checkbox"/> Itching	<input type="checkbox"/> Mucous Discharge	<input type="checkbox"/> Floaters
<input type="checkbox"/> Excess Tearing/Watering	<input type="checkbox"/> Burning	<input type="checkbox"/> Glare/Light Sensitivity	<input type="checkbox"/> Flashes
<input type="checkbox"/> Sties or Chalazion	<input type="checkbox"/> Foreign Body Sensation		<input type="checkbox"/> Tired Eyes
			<input type="checkbox"/> Other _____

When was your last exam? (Approximately) _____ Doctor's Name/Location: _____

Do you have any ocular diseases or disorders? None Dry Eyes Cataract Glaucoma Macular Degeneration
 Retinal Disorder Amblyopia Crossed Eye Trauma Other _____

Have you had any eye surgeries? None Lasik RK Cataract Retina Eyelid Other _____

Do you wear GLASSES? No Yes When do you wear your GLASSES? Full time Part time

Do you wear CONTACTS? No Yes

If you know the Brand of your contacts, please indicate: _____

Personal Medical History (Many general medical conditions affect the eye and your vision)

Please check this box if you **DO NOT** have any medical conditions.

Do you have problems with the following medical systems? (Please check all that apply in each box)

Constitutional <input type="checkbox"/> None <input type="checkbox"/> Weight loss <input type="checkbox"/> Fatigue <input type="checkbox"/> Trauma <input type="checkbox"/> Fever <input type="checkbox"/> Cancer <input type="checkbox"/> Other _____	Neurological <input type="checkbox"/> None <input type="checkbox"/> Multiple sclerosis <input type="checkbox"/> Epilepsy/Seizures <input type="checkbox"/> Headaches <input type="checkbox"/> Other _____	Gastrointestinal <input type="checkbox"/> None <input type="checkbox"/> Crohn's disease <input type="checkbox"/> Colitis <input type="checkbox"/> Ulcer <input type="checkbox"/> Digestive concern <input type="checkbox"/> Other _____
Allergic/Immunologic <input type="checkbox"/> None <input type="checkbox"/> Drug allergy <input type="checkbox"/> Environmental Allergy <input type="checkbox"/> Rheumatoid arthritis <input type="checkbox"/> Lupus <input type="checkbox"/> Other _____	Endocrine <input type="checkbox"/> None <input type="checkbox"/> Type 1 Diabetes <input type="checkbox"/> Thyroid Dysfunction <input type="checkbox"/> Type 2 Diabetes <input type="checkbox"/> Hormonal Dysfunction <input type="checkbox"/> Other _____	Musculoskeletal <input type="checkbox"/> None <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Muscular dystrophy <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Other _____
Cardiovascular <input type="checkbox"/> None <input type="checkbox"/> Heart disease <input type="checkbox"/> Stroke <input type="checkbox"/> Vascular disease <input type="checkbox"/> High Blood Pressure/HTN <input type="checkbox"/> High cholesterol	Blood/Lymphatic <input type="checkbox"/> None <input type="checkbox"/> Anemia <input type="checkbox"/> Leukemia <input type="checkbox"/> Other _____	Integumentary/Skin <input type="checkbox"/> None <input type="checkbox"/> Eczema <input type="checkbox"/> Rosacea <input type="checkbox"/> Psoriasis <input type="checkbox"/> Other _____
Genitourinary <input type="checkbox"/> None <input type="checkbox"/> Urinary tract infections <input type="checkbox"/> Kidney concerns <input type="checkbox"/> Herpes <input type="checkbox"/> Chlamydia <input type="checkbox"/> HIV <input type="checkbox"/> Other _____	Psychiatric <input type="checkbox"/> None <input type="checkbox"/> Depression <input type="checkbox"/> Panic Disorder <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Other _____	Respiratory <input type="checkbox"/> None <input type="checkbox"/> Asthma <input type="checkbox"/> Bronchitis <input type="checkbox"/> Emphysema <input type="checkbox"/> Upper respiratory tract infection <input type="checkbox"/> COPD <input type="checkbox"/> Other _____
Ears, Nose & Throat <input type="checkbox"/> None <input type="checkbox"/> Sinus Problem <input type="checkbox"/> Dry Throat/Mouth <input type="checkbox"/> Other _____	List other medical conditions not mentioned here: _____	

Medication History

Do you take any prescription or non-prescription medicines regularly? no yes If yes, please list all medicines:

Do you have any medication allergies: None known Penicillin Sulfa drugs Other: _____

Family Medical History

Is there any family medical history of any of the following? (If yes, please list their relationship to you)

<input type="checkbox"/> None	<input type="checkbox"/> Corneal disease	_____
<input type="checkbox"/> Blindness	<input type="checkbox"/> Lazy Eye	_____
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Diabetes	_____
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Heart Disease	_____
<input type="checkbox"/> Macular	<input type="checkbox"/> Hereditary Disease	_____
<input type="checkbox"/> Retinal	<input type="checkbox"/> Other Eye Disorders	_____

Social History

Use tobacco? No Yes Alcoholic Beverages? No Yes Illegal Drugs? No Yes
 Are you pregnant? No Yes Breast feeding? No Yes

Professional Service Policies

We strongly feel that all patients deserve from us the very best medical care that we can provide. Further, we feel that everyone benefits when definitive financial arrangements are agreed upon. Accordingly, we have prepared this material to acquaint you with our policy. **NO** prescriptions will be given until full patient balance is met. There are **NO REFUNDS** for professional service (eye exams, contact lens exam or medical visits) rendered unless a third party (such as an insurance company) is involved and they request it on your behalf.

We would also like to take this opportunity to familiarize you with our policies in regards to appointments and follow-up appointments. Appointments have priority over Walk-Ins. Walk-Ins are available only if time permits. Appointments have a 10 minute grace period; afterwards they are considered a walk-in.

Please read and understand the following about **Glasses Prescription Rechecks/Follow-ups**:

If follow-up is within 60 days of finalized prescription there is no charge

- 1) After 60 days of finalized prescription there is a \$35 fee (Patient must bring glasses to exam)
- 2) After 4 months patient must pay for a new full exam.

Our Contact lens follow up visits are intended to assess the quality of each patient's vision with the new contact lenses. We also determine if the patient is experiencing any adverse physiological changes secondary to wearing new contact lenses. These follow-up exams are usually scheduled within 1 to 2 weeks (depending on the type of contact lens) of dispensing the contacts. It is recommended to return with the contacts on unless they are causing a problem that makes wearing them too uncomfortable or not healthy for the eye.

Please read and understand the following about **Contact lens follow-up**:

- 1) Contact lens follow ups are **ABSOLUTELY** required unless a final prescription has been released according to our Contact lens release policy.
- 2) Contact lens fitting consists of 3 follow ups within a 60 day period of the original complete exam date at no charge.
- 3) Follow ups after 60 days of the complete exam will have a \$35 fee per visit, up to 4 months from complete exam date.
- 4) After 4 months of complete exam, patient must pay for a new complete exam in order to finalize their contact lens prescription.
- 5) **Contact Lens Returns:**
 - a. If you wish to exchange or return contact lenses, please return them within 30 days of your receipt of the product. **ONLY** unopened and unaltered contact lens vials or boxes may be returned or exchanged. Any boxes directly written on and/or marked by the customer will not be refunded or exchanged.

Insurance Information Release Policy

When making a third party claim, I authorize the release of my medical information to process my third party claim. I authorize Vision Today / James Powell, O.D. to file complaints on my behalf if my third party carrier does not properly handle my claim. I authorize the release of any information pertinent to my case to any third party, adjuster or attorney involved in resolving the financial status of my account. I authorize my third party plan to pay Vision Today / James Powell, O.D. directly. If my plan does not pay this claim, I agree to be responsible for the payment of these professional services.

Signing below acknowledges that you agree to our Insurance Information Release Policy and gives consent to the use and disclosure of Patient's health information for purposes of treatment, payment and healthcare options.

Signing below acknowledges that you were provided with a copy of your contact lens prescription at the completion of your contact lens fitting either in person or via our patient portal.

Signing below acknowledges that I have read and/or received a copy of Vision Today's Professional Service Policies and the Notice of Privacy Practices posted in the office.

Patient / Guardian Signature

Patient / Guardian Name Printed

Date