Martino Eyecare Patient Information

Welcome! Please take few minutes to fill out this form as completely as you can.
If you have any questions we will be glad to assist you.

Date:_____

Last name First name Date of Birth Age Sex

Address:_____ Email: _____

_____ Cell No._____ Alternate No._____

City_____ ST_____ Zip_____ Occupation_____

Parent's or Guardian's name if patient under 18 years of age, and in case of emergency, who we should contact:

Name_____ Relationship_____ Phone_____

How will you paying for your visit today? _____**medical insurance**_____**vision insurance**_____**self-pay**

WHAT IS THE PURPOSE OF YOUR VISIT TODAY?_____regular check up/glasses ____contact lenses ____both _____other

WHEN WAS YOUR LAST EYE EXAM? _____

Ocular History (please check all that apply)

Self (ocular):

_____ cataracts
_____ macular degeneration
_____glaucoma
_____ dry eyes
_____ eye infection, inflammation, or allergy
_____floaters/ flashes of light
_____ iritis or uveitis
_____ retina defects/degenerations
_____blurred/cloudy vision
_____ eye strain
_____ eye pain
_____ glare/severe sensitivity to lights
_____headaches
_____ poor night vision
_____ bothersome night glare
_____ double vision
_____ total loss of vision
_____ eye injury
_____eye surgery
_____lazy eye
_____others; please list
_____
_____

Are you having any of the following eye concerns? **(please check all that apply)**

_____Redness
_____Burning
_____itching
_____tearing
_____discharge

List all medications being taken_____
_____
_____
_____

List all allergies to medications_____
_____

Are you pregnant? YES NO **Are you nursing? YES NO**

Alcohol Use? YES NO ( ) Drinks / Week

Tobacco Use? YES NO ( ) Packs / Week

Drug Use? YES NO

Family History (medical): **(please check all that apply)**

	Cancer	Diabetes 1	Diabetes 2	High blood pressure	Hyperthyroidism	Hypothyroidism	Heart disease
Father							
Mother							
Brother							
Sister							
Son							
Daughter							

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

	Macular Degeneration	Blindness	Glaucoma	Cataracts
Father				
Mother				
Brother				
Sister				
Son				
Daughter				

How did you hear about us?

_____friend **_____vision center** **_____facebook** **_____internet** **other** _____

ADDITIONAL TESTS – PLEASE READ CAREFULLY

Dilation:

Dilation is the opening of the pupils by using medicated eye drops. This allows a better view of the retina and helps the doctor to detect many eye conditions that may be missed during a routine eye exam. Dilation is recommended for all patients but strongly encouraged for diabetic patients, patients with a history of glaucoma, cataracts, high blood pressure, high prescriptions, and other conditions. However, dilation may be necessary to determine a prescription for children. After being dilated, you will experience blurred near vision and light sensitivity. These effects can last from 3-6 hours or longer. ***The cost of this procedure is an additional $20***. **(Some insurance plans may cover cost)**

___Yes, I would like to be dilated today

___Yes, but I would need to reschedule for another day

___No, I do not want dilation

By signing below, I understand and release ***Martino Eyecare*** *and their doctors from all liability to treat or diagnose any eye condition due to lack of diagnostic information that could have been obtained from dilation.*

Please sign here if you do not want dilation _____ ***Date*** _____

1. All visits to the office are due and payable at the time of service
2. All fees are for professional services and therefore are non-refundable
3. Contact lens exam fees include up to 2 follow up visits within 30 days from the date of initial examination and/or receiving samples
4. I have received and read the Notice of Privacy Practices (HIPAA)
5. I agree to all of the terms mentioned above

Patient SIGNATURE _____ **DATE** _____

SIGNATURE _____ **DATE** _____

(parent/guardian signature in case of minor)

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Office use Only:

Spec or CTL

Insurance: _____

Co-Pay: _____

Private Pay: _____

CL Allowance: _____

Auth: _____

Payment Method:

Cash Check Visa Master Card Discover

American Express Care credit

Tonometry:

OD: _____ Time: _____

OS: _____

☐ Non-Contact ☐ GAT