PATIENT RECORD

Name: _____ Date of Birth: _____ Age: ___

Address: _____
(Street) (City) (Zip)

Home Phone: _____ Alternate Phone: _____ E-mail: _____

Reason for Today's Visit: _____

Do you currently wear eyeglasses? Y N What type: _____ Interested in LASIK? Y N

Have you worn contacts before? Y N Would you be interested in contacts today? Y N

Please list your current medications: _____

_____ Any allergies to medications? _____

DILATION OF THE PUPILS: This is the only way to have a thorough and complete eye examination. It allows your optometrist to obtain a better view inside your eyes in order to ensure optimal eye health. Health problems such as glaucoma, cataracts, retinal degeneration or tears, diabetes, high blood pressure and some tumors may be detected even before the onset of symptoms or loss of vision; and for this reason, it is required by the law of this State to be a part of all first-time routine exams. **There is no additional charge for this procedure.** *Dilation will temporarily result in blurred vision and sensitivity to light for about 2-4 hours.* Sunglasses will be provided if needed**.**

_____ I prefer to have a complete eye exam that includes dilation.

_____ I prefer to have a complete eye exam, **but would like to defer or reschedule the dilation**. I understand that there may be diseases, defects, lesions, or other problems of the eye or body associated or not associated with pain, vision loss, or other symptoms that were not examined or ruled out today; and as a result, I do not hold Michael S. Nason, O.D., P.A.; Steven L. Silverstone, O.D.; or We're All About Eyes, P.A., or their associates liable for any delay in diagnosis and treatment that may have resulted from my deferring dilation today. I understand that it is my or my guardian's responsibility to reschedule this portion of the exam. **If you do not want to be dilated today, you must sign here: Signature: _____**

INSURANCE RECIPIENTS: I authorize the release of any medical or other information necessary to process my insurance claims. I also accept request of government benefits either to myself or to the party who accepts assignment, further authorizing payment of medical benefits to the undersigned physician or supplier for services rendered. I understand that my signature on this form will serve as a permanent signature on file and will be used for accept assignment purposes only.

Primary Insurance Company: _____ Insurance ID: _____

Insured Name (Printed) _____ Insured Date of Birth _____

Insured Signature: _____ Date: _____

Supplemental Insurance Company: _____ Insurance ID: _____

Insured Name (Printed) _____ Insured Date of Birth _____

Insured Signature: _____ Date: _____

HIPAA ACKNOWLEDGMENT

My signature confirms that I have been provided with a copy of the Notice of Privacy Practices (NPP) of Michael S. Nason, O.D., P.A.; We're All About Eyes, P.A.; or Eyes on the Green, P.A.., and have been offered a copy of such policy to keep for my records.

HIPAA Signature: _____ Date:_____

For Office Use Only

I, _____, acting as Provider or Provider Representative, attempted to obtain written HIPAA acknowledgment of receipt of NPP on _____(date), but was unable due to Patient (or Patient's representative's) refusal, inability to sufficiently communicate, emergency circumstances, or other (circle one or please specify other reason here):_____. Signature of Provider or Representative:_____.

PATIENT'S MEDICAL HISTORY QUESTIONNAIRE

*Name:*_____ *Today's Date:*_____

Patient's Ocular History

Last Eye Exam: _____ *Dr.:* _____

(Please circle yes for any conditions that are present in your or your family's history):

			If Yes, Who?				If Yes, Who?
Crossed Eyes (Strabismus)?	*Yes*	*No*	_____	*Lazy eye (Amblyopia)?*	*Yes*	*No*	_____
Blindness?	*Yes*	*No*	_____	*Cataract?*	*Yes*	*No*	_____
Glaucoma?	*Yes*	*No*	_____	*Arthritis?*	*Yes*	*No*	_____
Macular Degeneration?	*Yes*	*No*	_____	*Cancer?*	*Yes*	*No*	_____
Retinal Detachment?	*Yes*	*No*	_____	*Diabetes?*	*Yes*	*No*	_____
High Blood Pressure?	*Yes*	*No*	_____	*Heart/Kidney Disease?*	*Yes*	*No*	_____
Thyroid Disease?	*Yes*	*No*	_____	*Lupus?*	*Yes*	*No*	_____

Patient's Social History

Occupation: _____

(strictly confidential, you may opt to leave this portion blank or discuss these items directly with the doctor)

Do you drive? Yes No *Do you have visual difficulty while driving? Yes No*

Do you use tobacco products? Yes No *If yes, type/amount/how long:*_____

Do you drink alcohol? Yes No *If yes, type/amount/how long:*_____

Patient's Review of Systems

Last Medical Exam: _____ *Dr.:* _____

(Please circle yes for any current or past history in the following areas)

CONSTITUTIONAL *(Fever, Weight gain/loss)*	*Yes*	***EARS, NOSE, MOUTH, THROAT***	
INTEGUMENTARY *(skin)*	*Yes*	*Allergies/Hay Fever*	*Yes*
NEUROLOGICAL		*Sinus Congestion*	*Yes*
Headaches	*Yes*	*Runny Nose*	*Yes*
Migraines	*Yes*	*Post-Nasal Drip*	*Yes*
Seizures	*Yes*	*Chronic cough*	*Yes*
EYES		*Dry Throat/Mouth*	*Yes*
Loss of Vision	*Yes*	***RESPIRATORY***	
Blurred Vision	*Yes*	*Asthma*	*Yes*
Distorted Vision/Halos	*Yes*	*Chronic Bronchitis*	*Yes*
Loss of Side Vision	*Yes*	*Emphysema*	*Yes*
Double Vision	*Yes*	***VASCULAR/CARDIOVASCULAR***	
Dryness	*Yes*	*Heart Pain*	*Yes*
Mucous Discharge	*Yes*	*High Blood Pressure*	*Yes*
Redness	*Yes*	*Vascular Disease*	*Yes*
Sandy/Gritty Feeling	*Yes*	***GASTROINTESTINAL***	
Itching	*Yes*	*Diarrhea*	*Yes*
Burning	*Yes*	*Constipation*	*Yes*
Foreign Body Sensation	*Yes*	***GENITOURINARY***	
Excess Tearing/Watering	*Yes*	*Genitals/Kidney/Bladder*	*Yes*
Glare/Light Sensitivity	*Yes*	***BONES/JOINTS/MUSCLES***	
Eye Pain or Soreness	*Yes*	*Rheumatoid Arthritis*	*Yes*
Chronic Infection of Eye or Lid	*Yes*	*Muscle Pain*	*Yes*
Stye or Chalazion	*Yes*	*Joint Pain*	*Yes*
Flashes/Floaters in vision	*Yes*	***LYMPHATIC/HEMATOLOGIC***	
Tired Eyes	*Yes*	*Anemia*	*Yes*
ENDOCRINE		*Bleeding Problems*	*Yes*
Thyroid/Other Glands	*Yes*	***ALLERGIC/IMMUNOLOGIC***	*Yes*
Diabetes	*Yes*	***PSYCHIATRIC***	*Yes*

If you answered YES to any of the above or have a condition not listed, please explain:

_____

_____

_____ _____

Doctor's Signature ***Date***