

Welcome To Our Office

Date: _____ / _____ / 2013

PERSONAL INFORMATION

Age: _____ Mobile Phone: _____
 Patient Name: _____ Date of Birth: _____ Bus. Phone: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Employer: _____ Occupation: _____
 Driver's License: _____ S.S.# _____ Have we seen other members of your family? _____
 Name of Parent/Spouse: _____ Level/if student: _____ School name: _____
 Pregnant: yes no Do you smoke: yes no Height: _____ Weight: _____
 How would you prefer to be contacted: Telephone Postage Email: _____

MEDICAL & VISUAL HISTORY

CHIEF VISUAL COMPLAINT: Poor Distance Vision Poor Near Vision Other _____
 Name of Physician & City: _____ Address/phone #: _____
 Name of last Eye Doctor & City: _____ Address/phone#: _____
 Please list any medical condition you are being treated for & how long: _____
 Please list any medications you are taking (including hormones, birth control, non-prescription): _____
 Please list any allergies to medications: _____ When was your last eye exam? _____
 Please list any pertinent past surgical history: _____
 Please check any medical conditions that apply to you (Review of Systems).

ALLERGIES: <input type="checkbox"/> _____ CARDIOVASCULAR/VASCULAR: <input type="checkbox"/> Diabetes <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Vascular Disease CONSTITUTIONAL: <input type="checkbox"/> Fever, Weight Loss/Gain ENDOCRINE: <input type="checkbox"/> Thyroid <input type="checkbox"/> Other Glands <input type="checkbox"/> Other, please list: _____	GASTROINTESTINAL: <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation GENITOURINARY: <input type="checkbox"/> Genitals/Kidney/Bladder HEAD: <input type="checkbox"/> Injury/Trauma <input type="checkbox"/> Bleeding Problems HEMATOLOGIC/LYMPHATIC: <input type="checkbox"/> Anemia/Bleeding disorders IMMUNOLOGIC: <input type="checkbox"/> _____	INTEGUMENTARY (skin): <input type="checkbox"/> _____ MUSCULOSKELETAL: <input type="checkbox"/> Muscles/Joints/Tendons/Ligaments/Nerves NEUROLOGICAL: <input type="checkbox"/> Headaches/Migraines <input type="checkbox"/> Seizures PSYCHIATRIC: <input type="checkbox"/> _____ RESPIRATORY: <input type="checkbox"/> Asthma <input type="checkbox"/> Chronic Bronchitis <input type="checkbox"/> Emphysema
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Please check all of the Symptoms of Conditions that apply to you.

<input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Sandy, Gritty Feeling	<input type="checkbox"/> Retinal Problems	<input type="checkbox"/> Mattering/Discharge
<input type="checkbox"/> Double Vision	<input type="checkbox"/> Burning, Stinging Eye(s)	<input type="checkbox"/> Painful Eye(s)	<input type="checkbox"/> Other _____
<input type="checkbox"/> Dry Eye(s)	<input type="checkbox"/> Tearing	<input type="checkbox"/> Blind Eye	Current Eye Medications: _____
<input type="checkbox"/> Itching Eye(s)	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Crossed Eye(s)	Eye Surgery / Injury in past: _____
<input type="checkbox"/> Lazy Eye	<input type="checkbox"/> Bumps on Lids	<input type="checkbox"/> Glare / Light Sensitive	
<input type="checkbox"/> Red Eye(s)	<input type="checkbox"/> Cataracts	<input type="checkbox"/> Swollen Eye(s)	

Please check Conditions that are present in other family members.

Cataracts Glaucoma Diabetes Heart Disease High Blood Pressure Macular Degeneration

Other Eye Diseases: _____

Other Inherited Conditions: _____

CONTACT LENS HISTORY

I would like to know my contact lens options. I am not interested in contacts. I have never worn contacts.
 Last time I wore contacts: _____ Problems with contacts _____

Daily Wear Extended Wear Disposable / Frequent Replacement
Rigid Gas Perm. Bifocal Other: _____
Solutions Used: _____

ARE YOU INTERESTED IN INFORMATION ABOUT LASER EYE SURGERY? Yes No

Dr. Matthew G. Barber

THERAPEUTIC OPTOMETRIST

ACTIVITIES & INTERESTS

- Football/Contact Sports
- Baseball / Softball
- Basketball / Volleyball
- Water Sports
- Dusty Work Environment
- I work with computers _____ hours/day.
- Soccer
- Other Hobbies/Activities _____

HOW DID YOU FIND OUT ABOUT OUR OFFICE?

- Mail Outs
- Phone Book
- Gift Certificate
- Location
- Media
- Other: _____
- Insurance
- © Direct Referral - Name: _____

DILATION

Dr. Barber strongly recommends that all patients receive a dilated eye examination every year. A dilated eye examination allows the doctor to evaluate the health of the retina and the inside of the eye. This aids the doctor in determining diseases such as macular degeneration, glaucoma, diabetic retinopathy, retinal holes and tears, cataracts, and tumors of the eyes.

The cost of dilation is \$20. Please select one of the following boxes below.

- ONLY CHECK ONE
- I **AGREE** to have my eyes dilated today and understand the importance of an annual dilated exam.
 - I **DO NOT** wish to have my eyes dilated today. And, I release Dr. Matthew Barber from any liabilities related to the failure to treat or diagnose any eye conditions due to the lack of diagnostic information which could have been obtained by these tests.

VISUAL FIELD TESTING

Dr. Barber recommends that all patients receive a Visual Field screening test. Visual Field testing is a quick procedure that measures a patient's peripheral and central vision. This type of testing provides the Doctor with a computerized map of your Visual Field. It helps the Doctor in the early detection and treatment of many eye diseases such as **Glaucoma** and **Macular Degeneration**. By mapping out the Visual Field, the doctor can also determine if there has been some type of vascular accident such as **Stroke** or **Brain Damage**, even interruption of visual communication due to **Tumors**. **The Visual Field Screening test is \$15.** Please select one of the following boxes below.

- ONLY CHECK ONE
- I **AGREE** to this procedure and understand the importance of a Visual Field Screening test.
 - I **DO NOT** wish to have the Visual Field Screening test. And, I release Dr. Matthew Barber from any liabilities related to the failure to treat or diagnose any eye conditions due to the lack of diagnostic information which could have been obtained by these tests.

Eye Screen RETINAL PHOTOGRAPHY

We are pleased to provide our patients with an advanced digital retinal exam called Eye Screen. Eye Screen is a high resolution screening photograph of your retina which will help us document, review, and compare your retina over time. We will use the Eye Screen photo to document a baseline image of your optic nerve, macular area, and main blood vessels that provide your retina with oxygen. This retinal image will allow Dr. Barber to screen for eye diseases and improve our ability to view your internal retinal health at a much higher resolution than traditional slit lamp or ophthalmoscope. **The Eye Screen photograph is \$30.** Please select one of the following boxes below.

- ONLY CHECK ONE
- I **AGREE** to have my retinal health evaluated with the Eye Screen retinal camera.
 - I **DO NOT** wish to have the Retinal Photographic Exam. I understand that I will still have a thorough eye examination with slit lamp observation.

INSURANCE RELEASE, PAYMENT RESPONSIBILITY AND PRIVACY POLICY

I hereby authorize the physician to release any information required to process this claim. I also authorize my insurance benefits be paid directly to the physician, and I understand I am financially responsible for non-covered services and possible fees associated with collecting unpaid balances. I have read and understand the Privacy Policy of this office (the Privacy Policy is available online at www.fortworthso.com in its entirety).

Patient Signature (or guardian)

Date

THANK YOU FOR ENTRUSTING US WITH YOUR EYECARE