WELCOME

CIRCLE ONE: Mr. Mrs. Ms. Miss Dr. **Today's Date:_____/_____/_____**

First________________________________Last____Middle Initial____________

Address:____City______________________State________Zip__________

Home Phone: (_____)__________________________________Business Phone: (_____)________________________________

E-Mail Address:_________________________________ Cell Phone: (_____)________________________________ (Optional)

Date of Birth:____________________Age:__________Social Security No.____

Marital Status:_______________ Race/Ethnicity:_____________ Communication Preference: Email Mail Phone Cell Phone

Occupation:____________________________________ Employer:____

How Were You Referred To Our Office? **Insurance: Web Page: Phone Book: Friend: Family: Other**__________________

Do you have **vision** insurance? VSP Davis Eyemed Superior Other____________________________

Do you have **medical** insurance? B/C B/S Aetna PHCS Cigna United Health Care Medicare

Other____

Name of policy holder____ His/Her D.O.B___________________

Relation to Patient____________________________ Insured's Social Security #__________________________________

YOUR VISION INFORMATION

What Is The Reason For Your Visit Today?____

How Long Since Your Last Eye Exam?____________Were Your Eyes Dilated For That Exam? Y / N / Don't Know

Do You Wear Eyeglasses? *YES / NO* Are you planning to get glasses today? *YES / NO / NOT SURE*

Do You Wear Contact Lenses? *YES / NO* Are you planning to get contacts today? *YES / NO / NOT SURE*

Type of Contacts you wear: Soft Gas Permeable Disposable Daily Overnight Occasional Use

Do You Currently, Or Have You Ever Had Any Problems In The Following Areas? **If YES, Please Give Dates:**

Retinal Detachment________________________ Glaucoma____
Cataracts _________________________________ Macular Degeneration____________________________
Crossed Eyes______________________________ Dry Eyes____
Lazy Eye_________________________________ Retinal Disease__________________________________
Other Vision / Eye Medical Problems: ____

YOUR MEDICAL HISTORY

Do You Have Diabetes?_________High Blood Pressure?___________Pregnant / Nursing?____________________

Do You Currently, Or Have You Ever Had Any Problems In The Following Areas? **If YES, Please Give Dates:**

Gastrointestinal _____________________ Musculoskeletal____________________________________
Nervous _____________________ Endocrine____
Cardiovascular _____________________ Integumentary (Skin)_______________________________
Ears, Nose, Throat_____________________ Allergic / Immunologic _____________________________
Respiratory _____________________ Genitourinary______________________________________

PLEASE CONTINUE ON THE OTHER SIDE

List Your Current Medications and Dosages:____

____

____

Allergies To Medications?:____

Other Allergies:____

FAMILY MEDICAL HISTORY

Please Note Any **Family History** For The Following Conditons: (Specify if Maternal/Paternal)

High Blood Pressure	Y / N	Relation____________	Macular Degeneration	Y / N	Relation________
Heart Disease	Y / N	Relation____________	Blindness	Y / N	Relation________
Diabetes	Y / N	Relation____________	Retinal Detachment	Y / N	Relation________
Glaucoma	Y / N	Relation____________	Cataracts	Y / N	Relation________
Crossed Eyes	Y / N	Relation____________	Thyroid Disease	Y / N	Relation________
Cancer (Type)	Y / N	Relation____________	Arthritis	Y / N	Relation________

Other Diseases or Conditions?__________________________Relation____________________________________

SOCIAL HISTORY

This Information is Kept Confidential. If You Prefer You Can Discuss This Portion Directly With The Doctor

Do You Use Tobacco?	Y / N	Have You Been Infected or Exposed To:	HIV, Hepatitis, STD's
Do You Use Alcohol?	Y / N	Do You Use Illegal Drugs?	Y / N
Do You Drive?	Y / N		

PUPIL DILATION RELEASE

We may be using drops to dilate (enlarge) the pupils of your eyes to observe the retina and other structures of the eye. This procedure can help in the early detection of eye disease and some systemic disorders. Side effects may include light sensitivity and short term blurry vision. The effects should wear off in several hours.

If dilating your eyes today is not possible or inconvenient you may elect to have a photograph of your retinas taken with our OPTOS digital camera. Dilation is not needed for the procedure. There is a minimal fee for the photos to be evaluated by the Doctor.

If you <u>do not want</u> your eyes dilated or <u>do not want</u> the digital photos taken at this visit please acknowledge by signing below.

I have been made aware of the benefits of these procedures in the early detection of disease and have chosen not to have my eyes dilated or have photos taken today.

Patient Signature:____Date:________________

AUTHORIZATION

I understand that:
1. Professional fees are due at the time of service.
2. A minimum deposit of 30% is required before glasses or contact lenses can be ordered.
3. I am ultimately responsible for all fees and material charges.

I affirm that all information above is complete and accurate to the best of my knowledge.

Patient Signature (or responsible adult):_________________________________Date:________________