Patient Information

Today's Date ____ / ____ / ____ Patient ID (office use only): _____

First Name _____Last Name _____ MI _____ Nickname: _____

Guardian (if patient is a minor): Name _____ Relationship _____

Date of Birth _____ Age _____ Occupation _____

Street Address _____

City _____ State ____ Zip _____

Home Phone _____Cell Phone _____ Email _____

Emergency Contact |Relationship _____|_____ Phone #_____

Would you like to receive appointment reminder/glasses or contacts pick up reminder via text message? Yes or No

May we send a customer service survey to your email? Yes or No

Last eye exam: □ < 6 months □ > 1 year □ > 3 year □ > 5 years □ 1st eye exam

How did you hear about our office? _____

Reason for today office visit: □ Annual Eye Exam □ Glasses □ Contact Lens □ Medical Problem
□ Consultation □ Other _____

Would you like to get more information on the following? (Please check all that apply)

□ Daily Disposable Contact Lenses □ Color Contact Lenses □ Progressive Contact Lenses

□ Prescription Polarized Sunglasses □ Latisse for Eyelash Growth □ Restasis for Dry Eye

□ Diabetic Eye Exam □ Glaucoma Exam □ Sports Glasses □ Safety Glasses □ Computer Glasses

Vision Insurance _____ Vision ID# / Group # _____

Medical Insurance _____ Medical ID# / Group# _____

HIPAA is a federal law that gives you rights over your health information and sets rules and limits on who can look at and receive your health information. You & Eyes may use or disclose your health information for treatment, payment, health care operations, appointment reminders, health-related products/services and to individuals involved in your care or payment for your care. We may also disclose your health information to avert a serious threat to health or safety, as required by law, for lawsuits/disputes and for workers compensation.

A copy of the **HIPAA Notice of Privacy Practices** (*your right to privacy*) is available upon request:

(Would you like a copy?) YES or NO

Patient's or Guardian's Signature: _____ Date ___ / ___ / ___

Family Medical & Eye Health History

Is there a family medical history of any of the following conditions? (If yes, please check the condition.)

□ Blindness □ Cataract □ Corneal/Retinal Disease □ Lazy Eye (Amblyopia) □ Crossed Eye (Strabismus)

□ Glaucoma □ Macular Degeneration □ Retinal Detachment □ Diabetes □ Heart Disease □ Cancer

□ High Blood pressure □ Autoimmune Disease □ Other _____

Social History

Do you drink alcohol? □ Never □ Occasionally □ 1 Drink/Day □ 2-3 Drinks/Day □ 4+Drinks/Day

Do you smoke cigarettes/tobaccos? □ Never □ Occasionally □ ½ Pack/Day □ 1 Pack/Day □ 2+ Packs/Day

Do you use illegal drugs? □ No □ Yes List_____

Have you ever been exposed to or infected with? □ Hepatitis □ Gonorrhea □ HIV □ Syphilis □ Herpes

(*Your social history is kept strictly confidential. However, you may discuss this portion directly with the doctor inside the room if you prefer*.)

Do you drive? Y / N

Do you have visual difficulty when driving? Y / N If yes, please describe: _____

Medical History

Name of Family Physician _____Physician's phone number _____

Physician's Address _____

Last Physical Check-Up: □ < 6 months □ > 1 year □ > 3 year □ > 5 years □ Never had one

Current Medications: Many medications can affect the health of your eyes. Please list the names of your medications including the name of over-the-counter drugs, eye drops, and birth control pills.

_____

_____

_____

Are you pregnant or nursing? □ Yes □ No

Do you have any allergies? □ Yes □ No If YES, please list_____ _____

List all major **injuries, surgeries, and/or hospitalizations** you have had:

_____

_____

Have you ever had eye infections, eye surgeries, and/or eye injuries? □ Yes □ No If yes, please explain:

_____

Review of Systems: Eye problems are often associated with problems from the rest of the body. Your answers to the following questions will be helpful in your examination. Please answer the following questions by checking the appropriate box if you have/had the following problems:

Ocular/Eye

Y / N Glaucoma
Y / N Cataract
Y / N Macular Degeneration
Y / N Previous Eye Injury
Y / N Burning
Y / N Itching
Y / N Tearing
Y / N Seeing Floating Spots
Y / N Seeing Flashing Lights
Y / N Double Vision
Y / N Crossed Eye
Other _____

General Health

Y / N Fever
Y / N Weight Gain/Loss
Y / N Loss of Sleep
Y / N Loss of Appetite
Y / N Fatigue
Other_____

Ears/Nose/Mouth/Throat

Y / N Deafness
Y / N Sinusitis
Y / N Sore Throat
Y / N Dental Problems
Other _____

Musculoskeletal

Y / N Arthritis
Y / N Osteoporosis
Y / N Fibromyalgia
Y / N Muscle Weakness
Other_____

Endocrine

Y / N Hypothyroidism
Y / N Hyperthyroidism
Y / N Diabetes
Other _____

Skin

Y / N New Moles
Y / N Skin Cancer
Y / N Acne Rosacea
Y / N Eczema
Y / N Dermatitis
Other _____

Psychiatric

Y / N Depression
Y / N Panic Attacks
Y / N Bipolar
Y / N Anxiety
Other _____

Neurological

Y / N Previous stroke
Y / N Seizures
Y / N Headaches
Y / N Multiple Sclerosis
Y / N Parkinson's disease
Y / N Alzheimer's disease
Y / N Light Headed/Dizzy
Y / N Numbness/Tingling
Other _____

Cardiovascular

Y / N High Blood Pressure
Y / N Chest Pain
Y / N Heart Valve Disease
Y / N Previous Heart Attack
Y / N High Cholesterol
Y / N Irregular Heartbeat
Other _____

Respiratory

Y / N Asthma
Y / N Chronic Bronchitis
Y / N Wheezing
Y / N Shortness of Breath
Y / N Chronic Cough
Y / N Tuberculosis
Y / N Emphysema
Y / N Pneumonia
Other _____

Gastrointestinal

Y / N Hepatitis
Y / N Ulcers
Y / N Pancreatitis
Y / N Colitis
Y / N Diarrhea
Y / N Constipation
Other _____

Genitourinary

Y / N Kidney Stones
Y / N Kidney Infection
Y / N Prostate Problem
Other _____

Blood/Lymphatic

Y / N Anemia
Y / N Blood Disorder
Y / N Sickle Cell
Y / N Lymphoma
Other _____

Allergic/Immunologic

Y / N HIV/AIDS
Y / N Allergies
Y / N Hay Fever
Y / N Autoimmune Disease
Other _____

Cancer

Y / N Skin
Y / N Breast
Y / N Lung
Y / N Prostate
Y / N Brain
Other _____

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

_____

_____

Patient's or Guardian's Signature: _____ Date ___ / ___ / ___

Reviewed by Dr._____ Date ___ / ___ / ___

CONSENT FOR TREATMENT, PRIVACY POLICY, NOTICE OF FINANCIAL RESPONSIBILITY, & RELEASE OF MEDICAL INFORMATION

Patient's Name: (please print) _____ _____

I consent to treatment necessary or desirable to the care of the patient mentioned above, including but not restricted to, drugs, medicines, materials or procedures that may be performed by the Doctor or qualified designate. I also acknowledge full responsibility for the payment of all services. I understand that the patient or responsible party is solely responsible for payment of all services, even though an insurance claim may be filed. If this account becomes delinquent, I agree to pay all costs of collection, including reasonable attorney's fees.

I understand that some services are not always covered as dictated by my insurance company based on medical necessity. I understand that if any treatment is rejected by my insurance plan as a non-covered procedure that I will be billed for those services. I also acknowledge as a member of these plans, that my insurance will be submitted by this office and, I will be responsible for paying all co-pays and/or deductibles at the time of visit. I authorize my insurance company to remit payment of medical benefits directly to You & Eyes.

By signing below you are acknowledging and accepting our office policies. If you have any questions regarding this form please speak with one of our associates before signing.

Patient's or Guardian's Signature: _____ Date ___ / ___ / ___

Dilation allows the doctor to examine the health of your eyes and detect certain conditions such as **cataract, glaucoma, tumor, retinal diseases, and vascular diseases.** These conditions and other ocular diseases may be **missed** if you do not dilate. *You will experience light sensitivity and **near** blurry vision after dilation*.

I (please circle one) **agree** or **do not agree** to be dilated:

Sign _____ Date ___ / ___ / ___

Digital Imaging Wellness Exam

- Sight-threatening eye diseases often have no outward signs or symptoms in the early stages.
- State-of-the-art technology allows the doctor to detect early signs of diseases such as glaucoma, macular degeneration, diabetic retinopathy, tumors, vascular diseases, and brain disorders, etc.
- Early detection and treatment of eye diseases may reduce your risk of vision loss.

The $29.00 charge is typically not covered by your vision or medical insurance, so this will be added into the cost of your visit today.

- ☐ I **understand** the importance of this test and accept responsibility for the additional payment of $29.00 today.
- ☐ I **decline** the importance of Digital Imaging Wellness Exam against medical advice.

Name _____ Date_____

Lifestyle Questionnaire

- How important is your vision to you? (Circle one)

1 Least	2	3	4	5 Most

- **Rank** the following in order of importance to you for glasses from 1 to 5 based on: (5 being most important)

Comfort	
Durability	
Style	
Hi-Definition Vision	
Cost	

- How long have you had your current prescription glasses? _____

- Do you notice scratches, smudges, fingerprints, and dust on your lens? Y or N

- Do you experience headaches, eye strain and/or blurry vision due to glare from headlights, sunlight, computer screens or fluorescent lights? Y or N

- Are you aware that sunlight UV rays cause the following:

  Eyelid/skin cancer Y or N
  Macular degeneration Y or N
  Cataracts Y or N
  Tissue mutation Y or N

<u>Don't miss out on our current promotions!</u>

- ***40% off complete second pair of glasses (frame and lens)***
- ***Buy an annual supply of contact lenses and receive 40% off complete pair of glasses (frames and lens)***
- ***25% off any non-prescription sunglasses***