

Do you wear glasses? No Yes If yes, how old is your present pair of glasses? _____

Do you currently wear prism glasses? No Yes If yes, what office prescribed them? _____

Do you wear contact lenses? No Yes If no, are you interested in trying contact lenses? Yes No

Type of contact lenses: Soft Hard Scleral Are they comfortable? Yes No

Contact Lens Brand: _____ How old is your present pair of lenses? _____

Do you drive? No Yes If yes, do you have visual difficulty when driving? No Yes

If yes, please describe: _____

FAMILY HISTORY

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

DISEASE/CONDITION	NO	YES	?	RELATIONSHIP TO YOU
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cross Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

SOCIAL HISTORY

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

I would prefer to discuss my Social History information directly with my doctor.

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

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

Do you use illegal drugs? No Yes If yes, type/amount/how long: _____

Have you ever been exposed to or infected with:

Gonorrhea Hepatitis HIV Syphilis

REVIEW OF SYSTEMS

Do you currently, or have you ever had any problems in the following areas:

<u>SYSTEM</u>	<u>NO</u>	<u>YES</u>	<u>?</u>	<u>SYSTEM</u>	<u>NO</u>	<u>YES</u>	<u>?</u>
CONSTITUTIONAL				EARS, NOSE, MOUTH, THROAT			
Fever, Weight Loss/Gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergies/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
INTEGUMENTARY (Skin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NEUROLOGICAL				Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Post-Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dry Throat/Mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
EYES				RESPIRATORY			
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Distorted Vision/Halos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	VASCULAR / CARDIOVASCULAR			
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sandy or Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	GASTROINTESTINAL			
Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	GENITOURINARY			
Excess Tearing/Watering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genitals/Kidney/Bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glare/Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	BONES / JOINTS / MUSCLES			
Eye Pain or Soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Infection of Eye or Lid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sties or Chalazion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Flashes/Floaters in Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	LYMPHATIC / HEMATOLOGIC			
Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ENDOCRINE				Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid/Other Gland	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ALLERGIC/IMMUNOLOGIC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				PSYCHIATRIC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

Doctor's Signature: _____ Date: _____



Patient Name: _____ DOB: _____
Last First MI

Responsible party for account: _____ DOB: _____ Phone: _____

Did anyone refer you to us? _____

Insurance Information

Primary Medical Insurance: _____ **ID#:** _____

Primary Insured's Name: _____ DOB: _____

Employer: _____

Vision Insurance: _____ **ID#:** _____

Primary Insured's Name: _____ DOB: _____

Employer: _____

Note: Most insurance policies pay only a portion of your total charges. If you have any questions about your coverage, please contact your representative. We do not guarantee the accuracy of benefit information given to us by insurance companies. Please understand that financial responsibility for your account is yours, not the responsibility of your insurance company. I authorize the release of any medical or other information necessary to process insurance claims. I authorize payment of medical or vision benefits either to the physician or supplier of services rendered or to myself if the provider does not accept assignment. I understand that I am responsible for any balance my insurance does not pay.

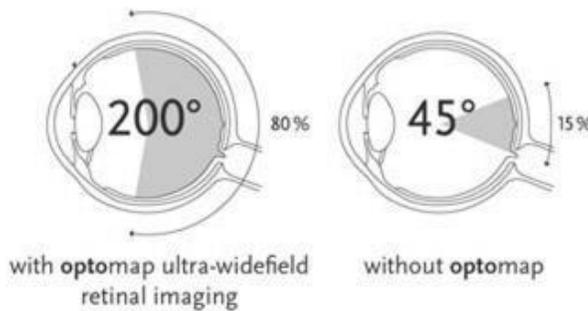
- All professional services, which includes eye examinations and office visits, must be PAID IN FULL when services are rendered.
- All materials, such as glasses and contact lenses must be PAID IN FULL before orders are placed.
- Any balance incurred as a result of not having a required referral or correct insurance information will be your responsibility.
- If your claim is denied for any reason or we have not received payment within 4-6 weeks from filing, you are responsible for the balance due within 30 days.
- We do not accept personal checks.

Patient or Guardian Signature _____ Date _____

OPTOMAP RETINAL IMAGING

We are pleased to be able to offer the Optomap Retinal Image Exam which allows our doctors to review an ultra-widefield view of the retina. Your retina (located in the back of your eye) is the only place in the body where blood vessels can be seen directly. This means that in addition to eye conditions (example: glaucoma, macular degeneration, retinal detachment), signs of other systemic disorders (example: diabetes, hypertension, stroke) can also be seen in the retina. Early signs of these conditions can show on your retina long before you notice any changes to your vision or feel pain. Getting an Optomap image is fast, painless and comfortable. Nothing touches your eye and is suitable for the whole family. Under normal circumstances, dilation drops are not necessary, but your eye care practitioner will decide if your pupils need to be dilated depending on your conditions.

Optomap	Dilation
NO blurred vision	Blurred near vision for 4-6 hours
NO light sensitivity	Light sensitivity for 4-6 hours
Shortens office visit (takes less than 2 mins)	Longer office visit to wait for drop to take effect (additional 30-45 minutes)
80% of your retina in one panoramic image	15% of your retina viewable at one time
You can see your retina	Only the doctor can see the retina



Our doctors recommend that **ALL** patients have a thorough examination of their retina every year. Without the Optomap or a dilated examination, the doctor cannot fully assess the health of your eye. There is an additional fee of \$39.00 for the Optomap. In most cases, this procedure is not covered by insurance. Dilation may still be required in rare instance.

I understand the above and elect to have my eyes dilated (*no additional charge*).

I understand the above and elect to have the Optomap Retinal Imaging (\$39.00).

I would like to refuse both the dilation and Optomap against my doctor’s recommendation.

Patient Name _____

Patient/Guardian Signature _____ Date _____