EYECARE REGISTRATION AND HISTORY

Date_____

Last Name: _____ First Name:_____ M.I.____ Sex:_____ Birth Date:_____

Mailing Address: _____ City:_____ State:_____ Zip:_____

Home Phone: _____ Work or Cell Phone:_____

Parent or legal Guardian Name(s) if patient is under 18 years: _____

Medications - (Including any eye drops):

_____

_____

Allergies - (List all your allergies to medications or other substances):

_____

Eye Health History

Date of last eye exam: _____

Where/Dr. Name?: _____

Do you wear glasses?: YES NO

☐ All the time ☐ Occasionally

☐ Reading ☐ Driving ☐ TV

Do you wear Contacts?: YES NO

Type/Brand:_____

Hours worn per day: _____

How many days per week do you sleep in your contacts?: _____

If you have had any of the following, please circle:

Crossed Eyes
Discharge from Eyes
Dizzy Spells
Double Vision
Dry Eyes
Bloodshot Eyes
Blurred Vision - Distance
Blurred Vision - Near
Burning Eyes
Cataracts
Color Vision - Poor
Eye Infection
Eye Injury
Eye Strain
Fainting Spells
Migraine Headaches
Night Vision, Poor
Red Eyes
Seeing Halos
Seeing Flashes of Light
Floaters or Spots
Glaucoma
Headaches
Itching Eyes
Light Sensitive
Loss of Vision
Temporary Loss of Vision
Twitching Eyelid
Vision Poor
Blackouts

What is your main reason for your visit today?: _____

_____

HEALTH HISTORY: Place a mark in the appropriate box if you or your blood relatives have had any of the following:

	YOU	Blood relative		YOU	Blood relative		YOU	Blood relative
Arthritis			Asthma			Cancer		
Retinal Disease			Blindness			Stroke		
Drug Sensitivity			Diabetes			Kidney Disease		
Eye Surgery			Glaucoma			Other		
Heart Condition			Thyroid Conditions					
High Blood Pressure			Lazy Eye					

Are you pregnant?: _____

Retinal Photography

A highly sophisticated camera now allows us to provide you with a more thorough medical analysis of your eye. The retinal imaging system takes photographs of the retina (the inside of your eye). This high-resolution digital photograph assists your doctor in the early detection of many disorders including:

*** Glaucoma** *** Diabetic Retinopathy** *** Macular Degeneration** *** Retinal Detachments**

The photos will become part of your medical records for comparison with photos from future exams. This allows your doctor to observe even the smallest amount of change from the previous examinations.

Our doctors highly recommend that their patients have retinal photography performed. It is especially important for people who have:

*** Headaches** *** Spots or flashes in vision** *** Cholesterol** *** Sudden changes in vision**
*** Family history of eye disease, diabetes, or high blood pressure** *** Never before taken retinal photos**

*There is an additional **$20.00 fee** for these pictures that your insurance cannot be billed for.*

☐ **NO,** I do not wish to have retinal photography done at this appointment.

☐ **YES,** I would like to have retinal photography performed. Please enter the last 4 digits of social security #/ or if you would prefer a different number (needed for identification in camera database).

☐☐☐☐

Notice of Privacy

I acknowledge that a Notice of Privacy practices was available for me to read. ☐ Initial this box

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Insurance Information: (If you are paying for your exam today, you can skip this section.)

Primary's Name: _____ Relationship to Patient: _____

Name of Employer: _____

I authorize the use of my signature on all insurance submissions. This doctor may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits for related services. I understand that I am financially responsible for all charges whether or not paid by insurance.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date