Email: _____

EYECARE REGISTRATION AND HISTORY

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			Macular Degeneration		
Heart Condition			Thyroid Conditions			Other		
High Blood Pressure			Lazy Eye					

Are you pregnant?: _____ Do you smoke?: _____ Race?: _____ Illegal Drug Use?: _____

Two Additional Screening Tests Available Today:

Retinal Photography

Our doctors recommend that all patients have retinal photography performed. This is a high-resolution digital photograph which can assist your doctor in the early detection of many disorders including:

* Glaucoma
* Diabetic Retinopathy
* Macular Degeneration
* Retinal Detachments

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

These photos become a part of your electronic medical records and is a baseline for comparison when the doctor is looking for even the smallest amount of change.

The cost for this screening is $20. As a screening, we will not bill this to insurance.

☐ YES, I want to have Retinal Photography.

☐ NO, I do not want Retinal Photography.

Visual Field Screening

A Visual Field can show early changes in your vision. The subtle changes in your vision may not be noticed by you until your vision loss is severe. Glaucoma is often called "The Sneak Thief of Sight" because it is a painless process which mostly affects the peripheral, or side vision first.

Other disease processes such as cataract, stroke, macular degeneration and diabetes can also influence the results of this test.

If you have: * Diabetes * Macular Degeneration * Headaches * Flashes of light/floaters * Changes in vision * Sleep Apnea * Thyroid Condition * A family history of Glaucoma, Macular Degeneration or Diabetes. (People with Sleep Apnea or any Thyroid Condition are approximately 25% more likely to develop glaucoma)

The cost of this screening is $21. As a screening, we will not bill this to insurance.

☐ YES, I want to have a Visual Field Screening.

☐ NO, I do not want a Visual Field Screening.

If you would like any Person(s) to have access to your medical records in our office, please list them below:

_____

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.)

Name of Insurance Company: _____

Policy Holder's Name: _____ Policy Holder's DOB: _____

Relationship to Patient: _____

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 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 paid by my insurance or not.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative **Date**