eyecare focused on you

Date: ____________

Patient Name: ____________ (Last) ____________ (First) ____________ (MI) Sex: M F

Address: ____________ (Number & Street) ____________ (City & State) ____________ (Zip Code)

Phone: ( ) ____________ (Home) ( ) ____________ (Work) ( ) ____________ (Cell)

Email: ____________ Preferred Method of Contact: _ Cell Phone _ Home Phone _ Work Phone

SSN: XXX - XX - ________ Age: _____ Date of birth ___/___/___ (Mo. Day Yr.) Spouse Name: ____________

Your Employer: ____________ Your Occupation: ____________

Primary Language: ____________

Emergency Contact: ____________ ( ) ____________ (Phone) ____________ (Relationship to Patient)

Race: Check one ❑ American Indian or Alaskan Native ❑ Asian ❑ Black or African American ❑ Native Hawaiian or Other Pacific Islander ❑ White ❑ Decline to Specify

Ethnicity: Check one ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Decline to Specify

Do you have vision insurance? VSP ❑ EyeMed ❑ Davis ❑ BCBS ❑ Medicare ❑

Has any household member been a patient here? Y / N Name(s) ____________

Responsible Party/Policy Holder Information: ____________ (Last) ____________ (First) ____________ (MI)

DOB ____________ SSN: XXX - XX - ____________

Would you permit dilation of your eyes if requested Y N ________ (please initial)

Have you ever had an allergic reaction to any medication or anesthesia Y N if so, which one(s) ____________

Services Requested today: _____ Vision Analysis/Eye Exam _____ Contact Lens Eval./Fitting

Urgent Care Services: _____ Eye Disease/Infection _____ Eye Injury _____ Foreign Body Injury

Other: ____________

Vision History

Do You Currently Have Glasses? Yes / No Age of Glasses? Do You Wear Contacts? Yes / No Type ____________

Last Eye Exam? ____________ Name of Eye Doctor ____________

Review Of Systems / Medical History (circle all specific conditions)

Have you ever had or do you have any of the following:

Yes / No Allergies (seasonal hayfever)
Yes / No Cardiovascular Disease (hypertension, chest pain, etc.)
Yes / No Endocrine disease (diabetes, thyroid, etc.)
Yes / No Genitourinary (kidney, bladder, etc.)
Yes / No Immunologic (immune disease, AIDS, etc.)
Yes / No Neurologic (headaches, migraines, seizure, etc.)
Yes / No Respiratory (asthma, emphysema, etc.)
Yes / No Other Health Problems ____________
Yes / No Ear, Nose, Throat (hearing loss, sore throat)
Yes / No Constitutional (fever, fatigue, weight change, etc.)
Yes / No Gastrointestinal (ulcers, reflux, liver disease, etc.)
Yes / No Hematological/Lymphatic (anemia, leukemia, bleeding)
Yes / No Musculoskeletal (arthritis, neck, back, etc.)
Yes / No Psychiatric (depression, anxiety, etc.)
Yes / No Skin/Breast (rash, growths, cancer, etc.)

List Medications Currently Taking and Condition for Which Prescribed

____

Name of Family Physician ____________ Last Physical Exam ____________

Ocular Health History / **Ocular Medications**

Do You Have.. — List All Eye Medications You Are Currently Using

Yes / No__ Color Vision Defect ____________
Yes / No__ Dry Eyes ____________
Yes / No__ Corneal Disease ____________
Yes / No__ Cataracts ____________
Yes / No__ Glaucoma ____________
Yes / No__ Retinal Detachment ____________
Yes / No__ Macular Degeneration ____________
Yes / No__ Eye Turning ____________
Yes / No__ Double Vision ____________
Other ____________

Family Ocular History

Any family members with.. — Relationship

Yes / No__ Color vision defect ____________
Yes / No__ Dry Eyes ____________
Yes / No__ Corneal Disease ____________
Yes / No__ Cataracts ____________
Yes / No__ Glaucoma ____________
Yes / No__ Retinal Detachment ____________
Yes / No__ Macular Degeneration ____________
Yes / No__ Eye Turn ____________
Yes / No__ Double Vision ____________
Other ____________

Have You Had Eye Surgery or Eye Injuries? Explain and Give Dates ____________

Social History

Do You Smoke? Yes / No Frequency ____________
Do You Drink Alcohol Yes / No Frequency ____________
Do You Use Drugs? Yes / No Frequency ____________

Please continue and sign the back of this form

How Did You Learn About Our Office: ___ Family ___ Friend ___ Coworker ___ Physician Referral
___ Insurance ___ Phone Book ___ Other:____________________

General Office Policies and Acknowledgment of Receipt

Eyeglasses: By signing, I agree to the following: If there are any adaption problems with my new prescription an appointment needs to be made within 30 days from the date of dispense. I understand there is no refund or credit for any downgrades made to my frame or lenses after ordering. I understand that I am responsible for the cost of new lenses after 30 daysfrom the date of dispense. I understand that Contact Lens Associations is not responsible for patient's own frames and will not give credit for patient's own frames damaged or broken during the re-lensing process.

Contact lenses: By signing, I agree to the following: I am responsible for paying a fitting fee that does not include the cost of my contact lenses. Since I have agreed to start the fitting process, I am responsible for making any necessary appointments to finalize my prescription. I understand that the fitting process may require more than 3 visits. I am responsible for any new charges for any visits after 90 days. If I am unable to wear contact lenses after the fitting process, or if I choose to stop the fitting process, I understand my fitting fee is non refundable and no credit will be issued. Any contacts returned will be subject to a restocking fee.

Your glasses and contact lens prescriptions are available upon request at any time. You will be provided one today. Please feel free to contact our office if you need a copy of your prescription(s).

HIPAA Privacy Notice: By signing, I understand and acknowledge the office Privacy Practice Notice and it has been made available to me.

Patient Name (please print): ____

Signature: ______________________________ Date: __________________

iCare

EIDON Ultra-widefield Retinal Imaging

The Eidon Retinal Imaging Exam:

- ✓ Is fast, easy, and comfortable
- ✓ May alleviate the need for dilation
- ✓ Provides a permanent record for annual review

An Eidon Retinal Image gives us a panoramic image of the surface of the retina. These images help the doctor assess the health of your eyes and check for conditions including macular degeneration, glaucoma, and retinal detachments. These problems can threaten vision without warning or symptoms.

Serious health problems unrelated to the eye such as diabetes, hypertension, heart disease, some cancers, and auto-immune disorders can also be viewed with an Eidon Retinal Image. Early detection could help save your vision or your life. If you have any questions please ask a staff member.

The cost of the Eidon Retinal Imaging is an additional $39 plus tax, not covered by insurance.

______ I ELECT to have the Eidon Retinal Imaging performed today at an additional cost of $39 plus tax and do not have any other questions.

______I DECLINE the Eidon Retinal Imaging today.

Print Name: ____

Signature: ____

Date: ____________________