



Welcome to Our Office

For faster service, please complete the following form prior to arriving at our office.

Date: _____

Patient's Name (please print) _____

If a Child, Parent's Name _____

Street Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ Cell Phone _____

E-mail Address _____ (to be used for office communication only)

Birth Date _____ M or F _____ Social Security # of patient/parent _____

Employer _____ Occupation _____

Spouse's Employer _____ Work Phone _____

Health Insurance Carrier _____ Policy # _____

How did you find out about our office? _____

I authorize the release of any medical information necessary to provide the most beneficial and complete visual examination. I understand that I am financially responsible for all charges whether or not paid by insurance. Payment is due at the time services are rendered.

Signature _____ Date _____

(Parent/Guardian Signature if under 18)

I plan on paying for my visit/copayments today with: (check one)

- Cash Visa Mastercard American Express CareCredit

Note: We do not accept personal checks/Discover Card

EYEZONE Medical History Record

For faster service, please complete the following form prior to arriving at our office.

Patient's Name (please print) _____

Birth Date _____ M or F _____

Emergency Contact _____ Phone Number _____

Date of Last Eye Exam _____ Name of Previous Eye Doctor _____

Personal Medical Information:

Do you have problems with any of these systems? If Yes, please check.

- | | |
|---|---|
| <input type="checkbox"/> Gastrointestinal | <input type="checkbox"/> Musculoskeletal |
| <input type="checkbox"/> Nervous System | <input type="checkbox"/> Blood/Lymph |
| <input type="checkbox"/> Mental | <input type="checkbox"/> Respiratory |
| <input type="checkbox"/> Ear/Nose/Throat | <input type="checkbox"/> Skin |
| <input type="checkbox"/> Genitourinary Endocrine (Glands) | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Cardiovascular | <input type="checkbox"/> Surgeries (what type & when) |

Are you in good health? Yes No

Any allergic reactions to medications or other substances? Yes No

If yes, please list _____

Name of general physician _____

Do you smoke? Yes/No How much? _____ Drink alcohol? Yes/No How much? _____

Do you take medications? Yes/No

Please list names & how often _____

Do you use other substances? Yes/No

Do you have family history of any of the following? If Yes, please check box.

- | | |
|--|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Macular Degeneration |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Retinal Detachment |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Cataracts |

(Please explain any boxes you have checked)

Do you have any of the following? If Yes, please check box.

- Dry Eyes
- Eye Surgeries
- Wear Glasses
- Blurred Vision
- Eye Injuries
- Wear Contacts

Any eye problems at this time? _____ Please explain _____

Are you interested in laser vision correction? Yes/No

Please sign below that you have reviewed all information above and it is correct to the best of your knowledge.

Signature _____ Date _____

HOBBIES AND OCCUPATIONAL QUESTIONS

Hobbies (check all that apply)

- Golf
- Fishing/Hunting
- Skiing
- Basketball/Baseball
- Hiking/Boating
- Cycling
- Sewing
- Reading
- Other _____

Occupation (check all that apply)

- Office
- Mechanic
- Sales
- Construction
- Medical
- Driving
- Computer Field
- Other _____
- Sensitive to Sunlight
- Trouble Reading
- Trouble with Night Driving
- Problems with glare from Sunlight

QUESTIONS AND ANSWERS ABOUT A DILATED EYE EXAMINATION

What is a dilated eye examination?

A dilated eye examination involves the use of eye drops to enlarge the pupil, which allows a large area of the retina, the interior lining of the eye, to be viewed. This view is vital to the proper diagnosis of the eye.

Who needs a dilated eye examination?

A dilated eye examination is recommended for any individual who has never had a dilated exam. The most common reasons for a dilated eye exam are:

1. Small pupils
2. High blood pressure
3. Diabetes
4. Symptoms of floaters or flashes of light
5. Cataracts
6. High degree of near-sightedness
7. Certain medication with ocular side effects
8. Family history of retinal disorders

Due to the increased incidence of ocular disease in the later decades of life, **ALL** patients over 50 years of age should have their eyes dilated annually.

How will the drops affect my vision?

After the drops are instilled, maximum dilation will occur in 20-30 minutes. At that time, the dilated examination can be performed. The effects of the drops will cause blurred vision, especially up close, as well as light sensitivity. Sunglasses are recommended. Please ask for disposable sunglasses if necessary.

Will I be able to drive?

Some patients experience difficulty with driving immediately following a dilated eye examination because of sensitivity to light and glare. If this will be your first dilation or if you have previously experienced problems driving when dilated, we recommend that you arrange for transportation.

Is there an extra charge?

No.

I have read and understand the above information. I **give / do not give** (circle one) the doctor permission to dilate my pupils.

Patient's Signature (Parent or Guardian if under 18)

Date



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PATIENT ACKNOWLEDGEMENT AND RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that, under the Health Insurance and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that the information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations, such as quality assessments and physician certifications.

By signing this document, I acknowledge that you have provided me with a copy of your Notice of Privacy Practice. This Notice of Privacy Practices contains a more complete description of the uses and disclosures of your health information.

I understand that this organization has the right to change its Notice of Policy Practices from time to time and that I contact his organization at any time at the address above to obtain a copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment of health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound by such restrictions.

Patient Full Name (Print): _____

Patient/Guardian Signature: _____

Witness Full Name (Print): _____

Witness Signature: _____

Date: _____