Precision eye care

Legal Name: _____ _____ Birth ___-___-___ Date___-___-___
(First) (Middle Initial) (Last) (Nickname)

Address: _____ _____ _____ _____
(street) (city) (state) (zip code)

Home phone: _____ Work phone: _____ Cell phone: _____

E-mail: _____@_____ Social Security # __ __ __ - __ __ - __ __ __ __
(Email used for Appointment confirmation, medical alerts ,recalls. Your privacy will be respected.)

Communication Preference: (circle one) Telephone or E-mail

Preferred Language: _____ Race/ Ethnicity: _____ Height**:** _____Weight:_____

Do you smoke? _____ If yes, how much?_____ If former, how long ago did you quit? _____

Marital status: _____ Employer: _____Occupation: _____

Driver License #_____ Exp. date_____ State_____

*How did you find out about our office (Please check **only one**)?*
___Yellow pages ___ Previous Patient
___ Internet
___ Other _____
___ Referred by another patient (Who may we thank?) _____

Parent/Guardian:_____
Birthday ____-____-_____
SSN __ __ __-__ __-__ __ __
Driver License #_____
Employer:_____
Home Phone:_____

Do you have these on a ***regular basis*** **without** glasses or contacts?

Blurred Vision	____
Floaters in eyes	____
Flashes of light	____
Burning Eyes	____
Itching Eyes	____
Watery Eyes	____
Dry Eyes	____
Eye Strain or pain	____
Headaches	____

Years since last eye exam_____
Last **Eye**-Doctor seen: _____

Primary Care Physician: _____
Years since last physical:_____

Have **you** or a **family member** had any of the following?

	You	**Family** (**relation to you**)
Diabetes	___	_____ _____
High blood pressure	___	_____ _____
Cardiac Trouble	___	_____ _____
Breathing/Asthma	___	_____ _____
Cancer	___	_____ _____
Allergies	___	_____ _____
Thyroid disorder	___	_____ _____
Macular Degen	___	_____ _____
Glaucoma	___	_____ _____
Retina problem	___	_____ _____
Lazy / crossed eye	___	_____ _____
Cataracts	___	_____ _____

List any eye surgery you have had:_____
_____
List any other medical/ocular conditions you have:
_____

List **ALL** current medications including prescription, over-the-counter, vitamins, or eye drops:
_____
_____

Are you allergic to any medications? Yes ___ No ___ If yes, please list: _____
Do you wear contact lenses? Yes ___ No ___ If yes, what type? _____
Are you interested in contact lenses? Yes ___ No ___

Please READ the following paragraph carefully before signing below

Eye Health Exam with Dilation of Pupils: During your examination, the Doctor may need to give you some mild eye drops to allow evaluation of the internal parts of the eyes for eye problems such as diabetes, cataracts, glaucoma, cancer, retinal detachments and other diseases. Your pupils will temporarily enlarge or "dilate". During the 2-4 hours after your examination, you will be light sensitive and may need to wear sunglasses. (If you didn't bring any today, please ask for a free pair at our front desk.) You may also have difficulty focusing at close distances, but this usually doesn't affect your distance vision. Some people feel more comfortable having someone else drive afterward, and a few people get a mild headache. Most eye doctors agree that all patients should have their pupils periodically dilated to determine if their eyes are healthy. This is especially important when the vision is not correctable to 20/20, or if the patient is very nearsighted, has floaters, flashes, diabetes, high blood pressure, history of eye surgery, recent head injury, above normal eye pressure, cataracts, or use of certain medications. *Sometimes dilation is required in order for the doctor to establish the proper glasses prescription or diagnosis.* The comprehensive eye examination begins at $79.00 (which includes dilation); however, additional tests may require additional fees.
There is no additional fee for dilation performed within 30 days of your exam.

1. Please check only one of the following options:

___ I **do** give permission to have the health of my eyes checked by dilation.

___ I **do not** give permission to have my eyes dilated & will not hold the doctor responsible for any diseases not diagnosed as a result of this omission.

___ I want to **reschedule** dilation (within 30 days).

___ I want to **discuss** dilation with the doctor.

Patient's Signature: _____ Date: _____
(or legal guardian if under 18 years old)

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2. Do you have Vision or Health Insurance that may pay for part of your eye examination?
____ Yes ____ No If yes, please present your insurance card/cards to the office assistant.

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3. If you are interested in *Contact Lenses*, please read & sign below:
Contact lenses are considered medical devices and are regulated by the FDA. Since they fit directly on the surface on the eye, extreme care and caution should be exercised in their use. Our office policy related to the purchase of contact lenses is as follows:

1. When ordering contact lenses, a minimum deposit of $20.00 is required for soft contacts, $50.00 for gas perm/hard lenses.

2. If you decide against contacts within 45 days of today, the amount paid on contacts will be refunded (***less the $20 administration fee for soft lenses, $50 for gas perm/hard lenses***.) Credit cannot be given for opened or damaged boxes of disposable contacts**.** Fitting/evaluation fees are also non-refundable. No refunds will be given after 45 days of today.

3. Due to strict return policies by the manufacturer of colored lenses, we require a 50% deposit before ordering. No credit/refund will be given for these contacts once the supply of boxes has been ordered.

Contact Lens Patient Signature: _____ Date: _____
(or legal guardian if under 18 years old)