Patient Historical Intake Date_____/_____/_____

Name_____ S.S#_____

If patient is a child - Parent's Name_____

If patient is a child - name of person accompanying child today and relationship

_____

Address_____City_____

State_____ Zip Code_____

Phone (Cell) _____ Date of Birth: _____Age_____

(Home)_____ Sex ☐M ☐F ☐non-binary

Do you prefer calls at: ☐home ☐cellphone ☐E-mail Occupation_____

EMAIL - You will receive appointment reminders, order notifications, yearly recalls, eye care news, and special promotions.

Our office may use e-messaging to contact patients. Do you prefer TXT messaging or e-mail? _____

MEDICAL INFORMATION RELEASE FORM (HIPAA Release Form):

❒ I authorize the release of information including the diagnosis, examination results rendered to me and billing.
This information may be released to:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

❒ I DO NOT authorize the release of this information to anyone.

The release of information will remain in effect until terminated in writing.

PERMISSION TO TREAT
COORDINATION OF BENEFITS, BILLING, STATEMENT OF INFORMATION ACCURACY:

I authorize the diagnosis of my ocular health by means of visual fields, photography, pachymetry, or other diagnostic testing deemed appropriate. I understand that certain procedures may not be covered by my insurance. I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the doctor to help determine appropriate treatment.

Payment in full is due the day that services are rendered unless arrangements are made prior to your visit. Fees for professional services i.e. exams, contact lens fittings are not refundable. I understand that I am financially responsible for any copays, deductibles, fees for non-covered services, etc. I am responsible for any outstanding balance for services provided that are not fully covered by my insurance, and may be billed for this remaining balance. I have provided accurate insurance information.

For your convenience, accepted forms of payment include cash, check, MasterCard, Visa and Discover.

_____ _____

Signature Date

*****Complete Both Sides of This Form or The Next Page***** _____reviewed by doctor

Patient Historical Intake Date_____/_____/_____

Date of last eye exam_____ Wear glasses? ☐Yes ☐No Contact Lenses? ☐Yes ☐No

How do you use your glasses? ☐all the time ☐work (safety) ☐computer ☐reading/near work ☐distance only

How old are your glasses? ☐1 year ☐ 2 year ☐ Other_____

Will you be getting eyeglasses today? ☐Yes ☐No Have a spare pair of glasses? ☐Yes ☐No

Do you wear sunglasses? ☐Yes ☐No Do you use blue filtered lenses while on a computer/phone? ☐Yes ☐No

SOCIAL HISTORY:

Are you pregnant and / or Nursing? ☐ No ☐ Yes If yes, how many weeks / months along are you?

Do you drink alcohol? ☐ No ☐ Yes How often? ☐ Social use ☐ 1-2 drink daily ☐ Other_____

Do you use tobacco product? ☐ No ☐ Former user ☐ Yes

How often? ☐ Less than 1pk / day ☐ 1-2pk / day ☐ More than 2pk / day

MEDICAL EYE HISTORY:

	SELF		FAMILY			SELF		FAMILY	
Cataracts	☐Yes	☐No	☐Yes	☐No	Eye surgery	☐Yes	☐No		
Eye injury	☐Yes	☐No			Lasik	☐Yes	☐No		
Lazy eye (amblyopia)	☐Yes	☐No	☐Yes	☐No	Blindness	☐Yes	☐ No	☐Yes	☐No
Glaucoma	☐Yes	☐No	☐Yes	☐No	Eye turn (strabismus)	☐Yes	☐No	☐Yes	☐No
Macular Degeneration	☐Yes	☐No	☐Yes	☐No	Poor color vision	☐Yes	☐No	☐Yes	☐No

If yes to Macular Deegeneration, do you have an Amsler Grid at home? ☐Yes ☐No

If yes to Macular Degeneration, do you have sunglasses?☐Yes ☐No Do you take AREDS 2 vitamins? ☐Yes ☐No

MEDICAL HEALTH HISTORY (Parents, Siblings, Grandparents):

	SELF		FAMILY			SELF		FAMILY	
Allergies	☐Yes	☐No	☐Yes	☐No	Heart Condition	☐Yes	☐No	☐Yes	☐No
Asthma	☐Yes	☐No	☐Yes	☐No	High Blood Pressure	☐Yes	☐No	☐Yes	☐No
Cancer	☐Yes	☐No	☐Yes	☐No	HIV +/ AIDS	☐Yes	☐No	☐Yes	☐No
Diabetes	☐Yes	☐No	☐Yes	☐No	Hormonal Disorders	☐Yes	☐No	☐Yes	☐No
Epilepsy / Seizures	☐Yes	☐No	☐Yes	☐No	Respiratory Disorders	☐Yes	☐No	☐Yes	☐No
Migraine Headaches	☐Yes	☐No	☐Yes	☐No	IV Drug Abuse	☐Yes	☐No	☐Yes	☐No
Psychiatric problems	☐Yes	☐No	☐Yes	☐No	Skin Disorders	☐Yes	☐No	☐Yes	☐No
Thyroid Problems	☐Yes	☐No	☐Yes	☐No	Neurological problems	☐Yes	☐No	☐Yes	☐No
Fever, Weight loss	☐Yes	☐No			Blood Disorders	☐Yes	☐No	☐Yes	☐No
Arthritis / Muscular	☐Yes	☐No	☐Yes	☐No	Stroke	☐Yes	☐No	☐Yes	☐No
*Kidney Disorders	☐Yes	☐No	☐Yes	☐No	Head injury	☐Yes	☐No		
*Liver Disease	☐Yes	☐No	☐Yes	☐No	History of Concussion	☐Yes	☐No	☐Yes	☐No

List all MEDICAL CONDITIONS and/or DISABILITIES that were not listed above: _____

_____

_____

_____

Primary Physician_____ Phone: _____

Physician's Address:_____

*****Complete Both Sides of This Form or The Next Page***** _____reviewed by doctor

Patient Historical Intake Date_____/_____/_____

Diabetic Patients:

When were you diagnosed?_____ Type 1 or Type 2 Diabetes? _____

What was your last A1C?_____ When was your last A1C?_____

Average blood sugar:_____ Do you check your sugar every day? ☐Yes ☐No

A diabetic exam report will be sent to your physician(s).

Physician:_____ Phone:_____

Address: _____

_____ Fax:_____

MEDICATIONS: List ALL Prescribed Medications, Vitamins, Over the Counter Eye drops, Over the Counter Medicines

_____

_____

_____

Do you take vitamins for ocular health? ☐Yes ☐No Are you on plaquenil for Lupus or RA? ☐Yes ☐No

ALLERGIES TO MEDICINES: _____

Pharmacy (Local):_____ City, State:_____

Pharmacy (Mail Order):_____Phone:_____

CONTACT LENS:

Are you a contact lens wearer? ☐Yes ☐No ☐No, but would like to be fit in contact lenses

Brand of your current contact lenses? _____

Type of lenses: ☐Soft…. ☐Gas Permeable (Hard)… ☐Toric (for astigmatism)… ☐Bifocal or Monovision

How often are your lenses replaced? ☐One Day ☐2 Weeks ☐ One month

Sleep in your contact lenses? ☐Yes ☐No

Brand of disinfectant solution used:_____

Are your current contact lenses comfortable? ☐Yes ☐No Do they dry out often? ☐Yes ☐No

OPTOS…..Ultrafield Retinal Imaging ……..No More Dilating Drops (*in most cases*)

As part of our pre-testing process, we perform ultra-field retinal imaging on ALL patients. This is important in assisting in the detection and monitoring of change each time you get your eyes examined. Glaucoma, Diabetes, & Macular Degeneration are diagnosed by detecting changes over time.

Retinal imaging is covered by your medical insurance with a medical diagnosis.

No medical diagnosis ----Patients who love the idea of protecting their vision and wish to have the doctor discuss the findings and to store the images as part of their annual examination record, the cost is $40.

Yes. I am choosing to include the Optos retinal imaging with my wellness exam _____ (initial)

*****Complete Both Sides of This Form or The Next Page***** _____reviewed by doctor