eye•de•ol•o•gy

vision center + optique

WELCOME TO OUR OFFICE!
OUR GOAL IS TO ENHANCE YOUR QUALITY OF LIFE WITH EACH ENCOUNTER.

PATIENT INFORMATION

Today's Date________________________________
Last ________________________________
First ______________________MI ________________
Street ________________________________
City ________________ State ________________
Zip Code ________________________________
Home Phone ________________________________
Work Phone ________________________________
Patient's SSN ________________________________
Employer (or School) ________________________
Occupation (or Grade) ____________________
Spouse (or Parent's Name) ________________________
Spouse (or Parent's Work) ________________________
Date of Birth ______________________Age _________
Sex M F
Email Address __________________________
How did you hear about us?______________________

Emergency Contact Name_________________________
Relationship________________________________
Phone________________________________

What is the major purpose of this visit?

____

Any problems with your current contact lenses or glasses?

Yes No

PATIENT EYE HISTORY

Date of Last Eye Exam______________________________
By Whom?________________________________

Do you wear eyeglasses? ☐ Yes ☐No
If yes, how old are your glasses?___________

Have you ever tried contact lenses? ☐ Yes ☐No

Do you currently wear contact lenses? ☐Yes ☐No
What kind?________________________________
Solutions used________________________________

What is your current contact lens prescription?
Right eye______________ Left eye____________

Are you satisfied with the vision and comfort of your contact lenses? ☐Yes ☐No

INSURANCE INFORMATION

Vision Insurance__________________________
Subscriber Name__________________________
Subscriber SSN__________________________
Subscriber Birth Date______________________________

Primary Medical Insurance___________________
Subscriber Name__________________________
Subscriber SSN__________________________
Subscriber Birth Date______________________________

Do you participate in a flex spending account?
☐Yes ☐ No

Digital Retinal Imaging
Digital Retinal Imaging (Optomap) allows us to capture photos of the retina, retinal blood vessels and optic nerve head for the purpose of early detection of many serious ocular and health diseases. ***In most cases, retinal imaging will NOT require dilation drops, which results in temporary blurred vision and light sensitivity, and is HIGHLY recommended by our doctors to be performed annually.** The fee for this service is $35.00 and is not a covered expense by your vision care or health plan if no pathology is detected, would you like this test?

YES NO

Dilation
If you have selected **NO** to having the retinal imaging performed, our doctors recommend a dilated eye examination to assess the health of your retina. The dilation is part of your examination and is covered by your insurance. The dilation will cause blurred near vision and light sensitivity for approximately 4-6 hours after instillation. Would you like this test?

YES NO

Visual Field Testing
In a matter of minutes, our Visual Field test can detect dysfunction in central and peripheral vision, which may be caused by various medical conditions such as glaucoma, stroke, brain tumors or other neurological deficits. This advanced technology allows us to detect problems earlier than a regular eye exam. The fee for this service is $25.00 and is not a covered expense by your vision care or health plan if no pathology is detected, would you like this test?

YES NO

PATIENTS SIGNATURE______________________________
DATE ____________________

The information in this confidential case history form is critical to the evaluation of your vision and health.

Patient/FAMILY Medical History

Name of Family Physician______________________
Town____
Date of Last Physical Check-up_________________________
Current Medications (Rx or Over the Counter)
(List name of medications including eye drops, vitamins, & birth control pills)______________________________________
____
____
Allergies to medications? ☐ Yes ☐No
If so, what medications?______________________________
____
Have you had any surgeries? ☐ Yes ☐No
Do you use cigarettes/tobacco, alcohol, or other substances? ☐Yes ☐No

Have you ever been diagnosed or treated for the following health problems?	**Yes**	**No**
Allergies	☐	☐
Arthritis	☐	☐
Autoimmune	☐	☐
Blood/Lymph	☐	☐
Bronchitis	☐	☐
Cancer	☐	☐
Cholesterol	☐	☐
Diabetes	☐	☐
Digestive	☐	☐
Ears/Nose/Throat	☐	☐
Endocrine	☐	☐
Eczema/Rashes	☐	☐
Fatigue	☐	☐
Genitourinary	☐	☐
High Blood Pressure	☐	☐
Integumentary (Skin)	☐	☐
Kidney	☐	☐
Muscle/Bone	☐	☐
Neurological	☐	☐
Psychological	☐	☐
Respiratory	☐	☐
Sinus	☐	☐
STDs	☐	☐
Throat Infections	☐	☐
Thyroid	☐	☐
Unusual weight losses/gains	☐	☐
If this applies - Are you pregnant or nursing?	☐	☐

Is there a family medical history of any of the following:

Check if yes	Relationship (Mother's or Father's side)
Blindness	☐____________________
Cataracts	☐____________________
Corneal Problems	☐____________________
Diabetes	☐____________________
Glaucoma	☐____________________
Heart Disease	☐____________________
Macular Degeneration	☐____________________
Other	☐____________________

Lifestyle Questions

Do you……(check box if your answer is yes)
☐..work at a computer? If yes, How much? _____Hrs/day
☐..think you might benefit from thinner, lighter lenses?
☐..spend time outdoors? How much? _____Hrs/week
☐..have prescription sunwear?
☐..prefer not to wear your glasses at times?
☐..want information on Laser Vision Correction surgery?
☐..have more than 1 pair of current Rx eyewear?
☐..have children?
☐..have family members in need of eyecare?

Have you ever experienced, been diagnosed or treated for any of the following?

☐Blurry Vision
☐Cataracts
☐Crossed eye/Eye turn
☐ Eye Infections
☐ Flash of light
☐Glaucoma
☐ Headaches
☐ Itchiness
☐ Macular Degeneration
☐ Retinal Detachment
☐Tearing
☐Uncomfortable glasses
☐Burning
☐Corneal Abrasions
☐Double Vision
☐ Eye Injury
☐Floaters/Spots
☐Grittiness
☐ Iritis/Uveitis
☐Lazy Eye
☐Occasional dryness
☐Sunlight Sensitivity
☐ Trouble seeing at night
☐ Other eye disorders______________________________

Please be advised if you are using insurance coverage for today's visit, this is a contract between you and your insurance company...not EYEDEOLOGY.

If your insurance company has not reimbursed our office in full, the balance becomes your responsibility. We will send a bill for any balance over 30 days old. Any account over 60 days old will be subject to a late fee.

Signature____
Date:______________________________

Privacy Policy
All doctor's offices must keep your information confidential due to laws known as HIPAA. We have given you our policies in regards to how we process your information on a separate sheet attached to this clipboard. Please sign below stating that you have read our statement or simply write "I decline to sign." (Your signature simply represents we attempted to share with you our HIPAA policies.)

Signature ____

Date____