Eye to Eye A MEMBER OF Vision Source

Office Use:

Exam Form

____
Last Name First Name MI

____
Address City/State/Zip

______________ ____ ______________ ____________________ ____________________
Date of Birth Gender SSN Mobile Phone Home or Daytime Phone

______________________________ ________ ______________________________
Email Address Marital Status Emergency Contact, Phone Number and his/her relation to you

______________________ ____________________________ ________________
Occupation Employer/School Employer/School Phone

__________________________________ __________________________________
Primary Care Physician and Phone Number Pharmacy and Phone Number

Please select which methods of communication are acceptable for you. Text _____ Phone Call _____ Email _____ Postal _____

What is the reason for today's visit? Do you have any specific concerns?

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We are proud to offer state of the art diagnostic tools that aid in diagnosing and managing certain eye diseases. These services may be especially of benefit if you have a history or family history of diabetes, glaucoma, headaches, high blood pressure, ocular trauma, high prescription, migraines, floaters, flashes of light, or any eye disease. **Pupil dilation is an important part of a comprehensive eye exam and may be necessary.** Dilating eye drops relax the pupil and facilitate a more thorough assessment of ocular health. **Dilating eye drops take approximately 20-30 minutes to take effect and may cause blurred vision and light sensitivity for several hours.** Most patients are able to drive home after a dilated examination. We provide two optional services to help determine potential risks to your eye health. Please review our provided information sheet for further details on available options. Please mark your selection

Yes, ____ Wellness Package for $55.00 **Yes,** _____ Optomap Retinal Imaging for $39.00 **Yes,** _____ Dilated Exam

No, ____ I don't want to be dilated or any of the offered services: **I understand this is not a complete eye health assessment.**

Do you wear glasses? No____ Yes____, if yes how many pairs and how old is your current pair? ________________________

Do you wear contacts? No___ Yes ___, if yes are you wearing them right now? No___ Yes___. If no are you interested to try contacts? No__ Yes__

If yes: 1. What brand and type? ____

2. Do you want to update your contact prescription today in order to continue wearing contacts? No ___ Yes ___

3. How often do you replace your contacts? ___________ How often do you replace your contact lens cases? __________

4. What contact lens solution do you use? ____

When was your last eye examination? Exact date not required if you cannot remember. ________________________

If this is your first time to our office, who was your previous eye care provider?
Please include contact # if possible. ____

Are you currently taking any medications including over-the-counter medications or supplements? If so please indicate dosage and frequency.

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____

Medication allergies or other allergens?

____

____

Form continues on other side. ➡

Medical History

When was your last physical or medical exam? ____

Have you had any eye injuries in the past? No ____ Yes ____, if yes please explain ____

Have you had any eye surgeries in the past? No ____ Yes ____, if yes please explain ____

Do you have any history of ocular procedures or diagnosed conditions? No___ Yes ____, if yes please explain ______________________________

____

Please make selection. If options do not apply, leave them blank. For family specify his/her relation to you next to choice

Eyes:	**Self**	**Family**
Dry eye	□	□
Glaucoma	□	□
Macular degeneration	□	□
Retinal detachment / disease	□	□
Cardiac:		
Heart disease	□	□
High blood pressure	□	□
Chest pain/tightness	□	□
Respiratory:		
Asthma	□	□
Bronchitis	□	□
Emphysema	□	□
GI:		
Constipation	□	□
Diarrhea	□	□
Inflammatory bowel	□	□

Integumentary:	**Self**	**Family**
Rashes	□	□
Dermatitis	□	□
Rosacea	□	□
Psoriasis	□	□
Eczema	□	□
Vitiligo	□	□
Neurological:		
Stroke / TIA	□	□
Headache / Migraines	□	□
Seizures	□	□
Endocrine:		
Diabetes	□	□
Kidney problems	□	□
Thyroid disease	□	□
Musculoskeletal:		
Arthritis	□	□

Hematologic:	**Self**	**Family**
Anemia	□	□
Sickle Cell Disease	□	□
Blood clots	□	□
Ears / Nose / Throat		
Chronic cough	□	□
Sinusitis	□	□
Dry mouth	□	□
Psychiatric:		
Depression	□	□
Anxiety	□	□
Other:		
Cancer	□	□
HIV	□	□
Hepatitis	□	□
Herpes	□	□

Please list any previous or current medical conditions not listed above and elaborate on the selections made including dates of diagnosis.

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____

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Please list any family medical or ocular conditions not listed above and elaborate on the selections made including dates of diagnosis and his/her relation to you.

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Please indicate any of these symptoms you may have been experiencing in the last 7 days, if none please leave blank.

- □ Eye injury from: ___________________
- □ Red eyes
- □ Eyes itch
- □ Watery eyes
- □ Eyes burn
- □ Eyes feel dry / gritty
- □ Foreign body sensation
- □ Eyelids swollen
- □ Eyelids crusty or stick together
- □ Mucus or filmy discharge
- □ Bump on eyelid
- □ Pain
- □ Headache
- □ Light sensitivity
- □ Blurred vision
- □ Double vision
- □ Halos
- □ Flashes or Floaters

Which eye? □ Right □ Left □ Both

When did the first of these symptoms begin to occur? ____

Briefly tell us what happened or any additional signs and symptoms you are experiencing.

____

____

____

Social History

Do you drive vehicles? No___ Yes___, if yes do you have any difficulty driving? No___ Yes___. Any difficulty seeing at night? No ____ Yes ____

Tobacco Use? Never smoked ___ Former smoker ___ Current every day smoker ___ Current some day smoker ___ Smokeless tobacco user _____

If former tobacco user, how long ago was your last use? ____

Do you consume alcohol? No ____ Yes ____, if yes how frequently do you consume? ____

Do you use recreational drugs of any kind? No ___ Yes ___, if yes how often to you use? ____

Have you ever had a blood transfusion? No ___ Yes ____, if yes please explain and include dates ____

Do you currently have a sexually transmitted disease? No ___ Yes ___, if yes what kind? ____

Are you pregnant or breastfeeding? No ___ Yes ___, if yes how many months? ____

Do you have any siblings? No____ Yes ____, if yes what is your birth order? 1st _____ 2nd _____ 3rd _____ 4th _____ 5th _____ Other ____________

My signature indicates:

1. **I have been informed of my rights under the HIPAA Privacy Policies.**
2. **I hereby authorize the doctor to release all information necessary to insurance providers to secure the payment of benefits.**
3. **I authorize the use of this signature on all insurance submissions.**
4. **As a potential contact lens wearer, I understand that based on the complexity of the contact lens evaluation, a separate fee ($75 - $120) will be charged regardless of the outcome of the evaluation. I understand I have 90 days from the initial exam to complete the contact lens prescription process without incurring any progress evaluation exam fees ($30 - $120). I understand the potential risks that exist in wearing contacts.**
5. **I understand that all fees paid for professional services are non-refundable and are payable at the time of service.**
6. **I understand that any purchases of spectacle lenses, frames, or contact lenses are non-refundable. Once purchase is made my signature indicates that I understand all re-refraction and lens redo's policies.**
7. **I understand that I have full financial responsibility for all charges whether or not paid by my insurance(s).**
8. **I understand that I will be billed whichever is appropriate based on the diagnosis from my exam and will be advised in difference of co-pay and/or deductible.**
9. **A copy of this agreement and redo policies available upon request.**

____

Signature (Or Legal Guardian if patient is under 18**)**

____ _________________

Print Name **Date**

Office Use Only:

New Pt / Est. Pt Arrival Time ________________ Appt. Time ________________

Vis Plan ____________________ Med I ns ________________________________ PP

CEE / CEE + CL / CL eval only / CL progress / PO progress

Refraction Check / Medical Testing / Topography

Wellness / Optomap / DFE _______ Re Auto Refract @_________________

VA - Unaided / CL / Spec

________________________________ **//** _________________________________

Pt Finalized / or RTC ____