

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Initial: _____
 Title: Dr. Master Miss Mr. Mrs. Ms. Rev. Nickname: _____ SS#: _____
 Street Address: _____ City: _____ State: _____ Zip: _____
 Birth Date: _____ Gender: M F Marital Status: S M Home Phone: _____
 Work Phone: _____ Cell Phone: _____ Email: _____
 Your preferred contact method: home phone work phone cell phone email
 Would you like to receive email for: monthly specials quarterly newsletter a reminder for your next eye exam (recall)
 Occupation: _____ Employer: _____ How did you hear of our office? _____
 Referred by: _____ OR: Insurance listing Family member Yellow pages Physician / Eye Doctor Ad

INSURANCE MEMBER INFORMATION

Name: _____ Relationship to patient: _____ Name of Vision Insurance: _____
 Name of Medical Insurance: _____ DOB: _____ ID#: _____ Group #: _____

HEALTH HISTORY

Primary Care Physician: _____ Medication Allergies: _____

Do **you or blood line relatives** have any of the following symptoms or conditions? **(check all that apply)**

	YOU	FAM		YOU	FAM		YOU	FAM		YOU	FAM
AIDS / HIV	<input type="checkbox"/>	<input type="checkbox"/>	CANCER	<input type="checkbox"/>	<input type="checkbox"/>	HEPATITIS	<input type="checkbox"/>	<input type="checkbox"/>	MIGRAINES	<input type="checkbox"/>	<input type="checkbox"/>
ALLERGIES	<input type="checkbox"/>	<input type="checkbox"/>	CATARACT(S)	<input type="checkbox"/>	<input type="checkbox"/>	HYPERTENSION	<input type="checkbox"/>	<input type="checkbox"/>	RETINAL DETAC	<input type="checkbox"/>	<input type="checkbox"/>
ARTHRITIS	<input type="checkbox"/>	<input type="checkbox"/>	DEPRESSION	<input type="checkbox"/>	<input type="checkbox"/>	KIDNEY DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	STROKE	<input type="checkbox"/>	<input type="checkbox"/>
ASTHMA	<input type="checkbox"/>	<input type="checkbox"/>	GLAUCOMA	<input type="checkbox"/>	<input type="checkbox"/>	LUPUS	<input type="checkbox"/>	<input type="checkbox"/>	THYROID	<input type="checkbox"/>	<input type="checkbox"/>
DIABETES	<input type="checkbox"/>	<input type="checkbox"/>	HEART COND	<input type="checkbox"/>	<input type="checkbox"/>	MACULAR DEG	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>

List other Medical Conditions: _____

List **ALL** Medications: _____

Tobacco use? _____ pack/day **Alcohol** use? Social 1-2 Drinks Daily Above Average **Females** – Pregnant Nursing

EYE HISTORY

Who was your previous eye doctor? _____ Last exam _____yr(s) Last dilation _____yr(s)

Reason(s) for this eye exam: _____

Special visual demands (work or hobbies) _____

Any past eye injury or surgery? Explain: _____

Any other eye history we should know about? _____

Have any blood line relatives had glaucoma, or other loss of sight? _____

Do you have any of the following symptoms or conditions? (check all that apply)

- Blurred distance vision
- Blurred near vision
- Double vision
- Poor night vision
- Red or bloodshot eyes
- Eyes feel dry
- Eye allergies
- Watery eye(s)
- Burning eyes
- Itchy eyes
- Computer strain
- Lazy eye
- Light sensitivity
- See flashes of light
- See "spots"
- Eye strain / fatigue
- Headaches
- Temporary loss of vision
- Twitching eyelid
- Pain in or around eyes

Have you ever worn **glasses**? YES NO When? Currently _____ years ago Used for? Distance Reading

Have you ever worn **contacts**? YES NO Last worn _____ Overnight wear? YES NO

What type is (was) worn? Disposable Non-Disposable Gas Permeable What brand is (was) worn? _____

Are you interested in **contact lenses** today? YES NO Are you interested in **laser vision correction**? YES NO

Patient Name _____

DIGITAL RETINAL IMAGING (DRI)

Digital Retinal Imaging is a new technology that allows instant viewing of retinal images by the doctor and the patient. It combines the technology of retinal photography and computerized digital imaging to produce remarkably clear retinal images. This computerized technology aids us by establishing baseline images of the inside of your eyes. We can then compare this image with future images and carefully observe any normal or abnormal changes. We believe this will promote earlier diagnosis of many abnormal vision conditions, some of which can result in permanent vision loss if not caught and treated in a timely manner. We recommend DRI for everyone but is especially important for patients who are at risk of developing eye disease, such as **diabetics**, patients with **high blood pressure**, those at risk of age related **macular degeneration** and those with family history of **glaucoma**. Our fee for this procedure is **\$25.00**. Medical insurance reimburses for this test only when there is eye disease present but not as a baseline. We are overwhelmed with the results of this procedure and highly recommend it as an optional addition to your exam today.

Would you like baseline Digital Retinal Imaging today? YES NO

VISUAL FIELD TESTING

Visual field testing is performed for early diagnosis of eye disease. If you would like a more detailed visual field screening, which can help detect glaucoma, neurological conditions, and other types of disease check YES below? It is an **ADDITIONAL TEST** and costs an **EXTRA \$15.00**.

Would you like to take this test? YES NO

INFORMED CONSENT FOR DILATION OF EYES

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the doctor to get a better view of the inside of your eye. Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your doctor to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it's best if you make arrangements not to drive yourself. Adverse reaction, such as acute angle-close glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

Is it OK to dilate your eyes today? YES NO

CONSENT FOR TREATMENT, PRIVACY NOTICE ACKNOWLEDGEMENT, AND INSURANCE RELEASE

I hereby give consent to Fisher Eye Associates. to provide whatever treatment they may deem necessary to the patient above. I understand that I am responsible for charges incurred for services. I understand I am responsible for charges not covered by the insurance policy. I acknowledge I have received a copy of Fisher Eye Associates Notice of Privacy Practices, which outlines how my health information is utilized. I hereby request payment of authorized insurance benefits for me to be paid directly to Fisher Eye Associates for any services furnished to me by Fisher Eye Associates. I authorize Fisher Eye Associates to release to my insurance carrier and its agents any information concerning health care, advice, treatment or supplies provided me needed to determine these benefits or the benefits payable for related services. I understand this is a lifetime authorization.

X _____
SIGNATURE / PATIENT AUTHORIZATION DATE

X _____
SIGNATURE / SPOUSE OR GUARANTOR DATE