WELCOME TO FISHER EYE ASSOCIATES

Dr. David & Holly Fisher

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: _____

Preferred Language: _____ Race: _____ Ethnicity: _____ Preferred contact method:_____

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 (Please present any insurance cards)

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 immediate family (blood line)** have any of the following symptoms or conditions? **(check all that apply)**

	YOU	FAM		YOU	FAM		YOU	FAM		YOU	FAM
AIDS / HIV	❑	❑	CANCER	❑	❑	HEPATITIS	❑	❑	MIGRAINES	❑	❑
ALLERGIES	❑	❑	CATARACT(S)	❑	❑	HYPERTENSION	❑	❑	RETINAL DETAC	❑	❑
ARTHRITIS	❑	❑	DEPRESSION	❑	❑	KIDNEY DISEASE	❑	❑	STROKE	❑	❑
ASTHMA	❑	❑	GLAUCOMA	❑	❑	LUPUS	❑	❑	THYROID	❑	❑
DIABETES	❑	❑	HEART COND	❑	❑	MACULAR DEG	❑	❑		❑	❑

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

Please fill out page #2

OPTOMAP RETINAL EXAMINATION

Our doctors at Fisher Eye Associates are concerned about retinal problems including macular degeneration, glaucoma, retinal holes or detachments, and systemic diseases such as diabetes, high cholesterol and high blood pressure. These conditions can lead to serious health problems including partial loss of vision or blindness, and often develop without warning and progress with no symptoms.

The Optomap Retinal Exam:

- ✓ Provides your doctor with a scan of the retina to confirm the health of your eye
- ✓ An in depth view of the retinal layers (where disease can start)
- ✓Allows your doctor to detect the presence of disease early in its progression
- ✓ Will be saved in your medical file enabling your doctor to make important comparisons during your annual eye examination

As part of your pre-examination work-up, our clinical associate will perform the retinal image which your doctor will review with you during your examination today. The $39 charge is typically not covered by your medical or vision insurance unless being used to actively follow disease. Typically the cost of this technology would be much greater but we have discounted the images to be able to offer them to every patient. This cost will be added into the price of your visit today. Any questions you have about these tests can be discussed during your examination.

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. **Routine vision exams** will be filed with a patient's vision plan if you have one. A routine exam means there is not a medical diagnosis. Routine diagnoses are vision diagnosis only. If a **medical diagnosis** is determined by the doctor the patient's exam in no longer routine, but medical. This means we could bill your Health (Medical) Insurance instead of your vision plan. We request a copy of your medical card in your chart for these reasons. 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