

NAME (last) _____ (first) _____ (m) _____ DATE _____

PARENT/GUARDIAN _____ Ethnicity _____ M _____ F _____

ADDRESS _____ AGE _____

CITY _____ ST _____ ZIP _____ BIRTHDATE _____ SS# _____

OCCUPATION _____ HOME PHONE _____ WORK PHONE _____ CELL _____

EMPLOYER _____ EMAIL _____

VISION INS _____ POLICY# _____ MEDICAL INS _____ POLICY# _____

POLICHOLDER NAME (last) _____ (first) _____ (m) _____ SS# _____

WHO MAY WE THANK FOR REFERRING YOU _____

ADVANCED GLAUCOMA SCREENING

Glaucoma is the leading cause of preventable blindness in the United States and early detection is critical to preserve vision. We offer an advanced Glaucoma screening using two state of the art diagnostic instruments. This screening test is recommended for all patients 40 years of age and older. The cost is \$30.00 and is **NOT** covered by insurance. Accept _____ Decline _____

DILATION

We may need to install drops to examine the inner wall of your eyes. These drops may cause some sensitivity to light and blurred vision.

May we use diagnostic drops to dilate your eyes? Accept _____ Decline _____

Notice of Privacy Practices

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I have been provided with a Notice of Privacy Practices that gives a more complete description of information uses and disclosures as well as a description of my privacy rights. I understand that I can review the notice prior to signing this acknowledgement. I understand that the organization reserves the right to change their notice and practices and will provide me a copy of any revised notice.

EMERGENCY CONTACT NAME (last) _____ (first) _____ PHONE _____

WHO MAY WE SHARE YOUR INFORMATION WITH (last) _____ (first) _____

We reserve the right to charge \$25.00 for appointments missed without 48 hours notice.
Accounts over 90 days past due are subject to a \$25.00 late fee.

I have reviewed and understand the information contained on this form.

PATIENT NAME _____ WITNESS _____
(Signature of Patient or Legal Representative)

<u>EYE HEALTH HISTORY</u>				<u>FAMILY HEALTH HISTORY</u>			
Last Eye Exam _____		Glasses _____		Contact Lenses (type) _____		Yes No	
	Yes	No	(Specify Right or Left eye)				
Injuries	<input type="checkbox"/>	<input type="checkbox"/>			Crossed Eye	<input type="checkbox"/>	<input type="checkbox"/>
Prosthesis	<input type="checkbox"/>	<input type="checkbox"/>			Lazy Eye	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>			Blindness	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>			Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Retina	<input type="checkbox"/>	<input type="checkbox"/>			Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Lazy Eye	<input type="checkbox"/>	<input type="checkbox"/>			<u>CURRENT EYE MEDICATIONS</u>		
Macular Drusen	<input type="checkbox"/>	<input type="checkbox"/>					
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>					
Corneal Scar	<input type="checkbox"/>	<input type="checkbox"/>					
Keratconous	<input type="checkbox"/>	<input type="checkbox"/>					
Dry Eye	<input type="checkbox"/>	<input type="checkbox"/>			<u>CURRENT MEDICATIONS</u>		
Nevus	<input type="checkbox"/>	<input type="checkbox"/>					
Floater	<input type="checkbox"/>	<input type="checkbox"/>					
	<input type="checkbox"/>	<input type="checkbox"/>					
Please circle all conditions that apply				<u>MEDICAL HISTORY</u>			
				Yes No (If yes, please describe)			
Cardiovascular- Heart \ Cholesterol \ Hypertension \ Stroke			<input type="checkbox"/>	<input type="checkbox"/>			
Constitutional- Fever \ Weight Loss			<input type="checkbox"/>	<input type="checkbox"/>			
Endocrine- Diabetes \ Thyroid Condition			<input type="checkbox"/>	<input type="checkbox"/>			
Gastrointestinal- Acid Reflux \ Ulcers \ Hepatitis			<input type="checkbox"/>	<input type="checkbox"/>			
Genitourinary- Bladder \ Menopause \ Prostate			<input type="checkbox"/>	<input type="checkbox"/>			
ENT- Ear \ Nose \ Throat			<input type="checkbox"/>	<input type="checkbox"/>			
Hematologic, Lymphatic- Anemia \ Cancer \ Sickle Cell			<input type="checkbox"/>	<input type="checkbox"/>			
Immunological- Herpes Simplex \ Shingles \ HIV			<input type="checkbox"/>	<input type="checkbox"/>			
Integumentary- Acne Rosacea \ Lupus			<input type="checkbox"/>	<input type="checkbox"/>			
Musculoskeletal- Arthritis \ Osteoporosis			<input type="checkbox"/>	<input type="checkbox"/>			
Neurological- Migraine \ Multiple Sclerosis \ Parkinsons			<input type="checkbox"/>	<input type="checkbox"/>			
Psychiatric- Anxiety \ Dementia \ Depression			<input type="checkbox"/>	<input type="checkbox"/>			
Respiratory- Asthma \ Emphysema \ Tuberculosis			<input type="checkbox"/>	<input type="checkbox"/>			
Reproductive- Pregnancy \ Menopause			<input type="checkbox"/>	<input type="checkbox"/>			
Cancer \ Other medical problems-			<input type="checkbox"/>	<input type="checkbox"/>			
<u>EYE SURGERIES</u>				<u>DRUG ALLERGIES</u>			
				<u>SOCIAL HISTORY</u>			
				Smoker: Y N			
				Alcohol: Y N			
				Drugs: Y N			
Pharmacy Name _____				Location _____			
Primary Care Physician _____							