

(Please print the answers to all questions. Your information will remain confidential per HIPAA)

We take Medical Insurance and Vision plans so kindly provide information for BOTH {Please hand in cards to scan}

□Mr. □Mrs. □Miss □Dr.	Sex: Male Female If min	or, Parent/Guard	lian Name:		
Name:			Date:		
First	Middle	Last			
Address:	Apt #	City	State Zip		
Cell Phone:	Home Phone:		Work Phone:		
Date of Birth:	Age: Email Address:				
Occupation (or School Grade): Employer (or School):					
Personal Eye History What is the Reason for your visit today?					
Have you had any of the following problems? D Blurred vision Red eyes Glare D Double vision Dryness I Itching Allergies					
🗅 Tearing 🗅 Macular Degeneration 🗅 Floaters 🗅 Flashes 🗅 Headache 🗅 Cataracts 🗅 Glaucoma 🗅 Retinal problem 🗅 Eye pain 🗅 Injury					
□ Lazy eye □ Iritis/Uveitis □ Gritty feeling □ Light sensitivity □ Crossed eye/Eye turn □ Twitching □ Other					
Eye surgery: 🗅 None 🗅 Lasik 🗅 PRK 🗅 Cataract 🗅 Retina 🗅 Glaucoma 🗅 Eyelid 🗅 Other					
When was your last exam? (Approximate) Doctor's Name/Location:					
Family Eye History Does anyone in your family have a history of any of the following problems?					
□ Macular Degeneration □ Glaucoma □ Retinal problems □ Crossed eye □ Cataracts □ Other					
Do you wear GLASSES?	□ No	If YES, do you	1 have them with you TODAY ? D Yes D No		
When do you wear your GLASSES? Full time Part time Reading Distance/Driving Computer Use Safety					
Hours per day on Computer, Tablet, Phone, or Reading: 🗆 1-3 🗆 3-6 🗅 6+ Hrs. Eyes BURN/STING during these activities? 🖵 Yes 🗅 No					
Do you Wear CONTACTS? Yes No		Have yo	Have you EVER worn Contacts before? 🗆 Yes 🗅 No		
What Kind? 🗆 Astigmatism/Toric 🗆 Color 🗆 RGP 🗆 Spherical 🖨 Bifocal 🖨 Monovision 🖨 Monthly 🖨 2 Weeks 🖨 Daily Disposable					
What is the BRAND and POWER of your old contacts? Do you SLEEP in contacts □ Yes □					
How often do you replace your contact lenses? End of day DRYNESS? 🗆 Yes 🗅 No Contacts BLURRY? 🗅 Yes 🗅 No					
Would you be interested in being fit with the latest contact lens technology?					

PLEASE TURN OVER AND FILL OUT BACK SIDE

Social History BMI info: Heightftin. Weightlbs. Race/ Ethnicity					
Tobacco use? □ Yes □ NoAre you pregnant? □ Yes □ NoBreast feeding? □ Yes □ No					
Personal Medical History Many general medical conditions affect the eye and your vision					
Who is your Primary Care Physician ?					
List all MEDICATIONS you take:					
Do you have any Drug allergies: Done known Denicillin Sulfa drugs Other:					
Check this box if NO medical conditions apply. Otherwise (<i>Please check all that apply in each box</i>)					
ConstitutionalImage: NoneImage: Weight lossImage: FatigueImage: TraumaImage: FeverImage: CancerImage: Cancer	Neurological □ None □ Multiple Sclerosis □ Epilepsy □ Headaches □ Seizures □ Migraines	Gastrointestinal INone Acid Reflux Colitis Ulcer Crohn's disease			
Allergic/Immunologic Image: None Image: Drug Allergy Image: Environmental Allergy Image: Rheumatoid Arthritis Image: Lupus	Endocrine Image: None Image: Type 1 Diabetes Image: Type 2 Diabetes Image: Thyroid disorders Image: Hormonal dysfunction	MusculoskeletalImage: NoneFibromyalgiaImage: Muscular DystrophyOsteoarthritis			
CardiovascularIn NoneImage: Heart diseaseStrokeVascular diseaseImage: High Blood Pressure/HTNHigh Cholesterol	Blood/Lymphatic □ None □ Anemia □ Leukemia □ Bleeding disorders	Integumentary/Skin□ None□ Eczema□ Rosacea□ Psoriasis□ Skin Cancer□			
Genital, Kidney, Bladder □ None □ Urinary Tract Infection □ Kidney concerns □ STD: Herpes, Chlamydia, etc. □ HIV	Psychiatric □ None □ Depression □ Anxiety □ Insomnia □ Anxiety	Respiratory Image: None Asthma Bronchitis Emphysema COPD COPD Emphysema			
Ears, Nose & ThroatImage: NoneImage: Upper Respiratory Tract InfectionImage: Sinus	Premature at birth	□ Other			

Dilated Retinal Exam

As part of a comprehensive eye exam, dilation is highly recommended. Drops are instilled so the doctor may see more peripherally in the back part of the eye. It is especially recommended on your first eye exam, if you have diabetes, high blood pressure, previous retinal issues, flashes/floaters, or a high nearsighted prescription. This procedure does take an additional 30 minutes and will blur your near vision for 4-6 hours. Some people do not feel comfortable driving after dilation due to light sensitivity and some slight distance blur. *The dilation is not included in some insurances or the basic wellness exam. There is a \$35 additional fee.* The Doctor may require you to dilate your eyes based on findings during the exam to get an accurate health diagnosis.

I would like to DILATE my eyes today I would NOT like to Dilate my eyes today I will reschedule Dilation

Insurance Information Release

When making a third-party claim, I authorize the release of my medical information to process my third-party claim. I authorize NovaEyes/Paul Cho and Associates, PLLC to file complaints on my behalf if my third-party carrier does not properly handle my claim. I authorize the release of any information pertinent to my case to any third party, adjuster or attorney involved in resolving the financial status of my account. I authorize my third-party plan to NovaEyes/Paul Cho and Associates, PLLC directly. If my plan does not pay this claim, I agree to be responsible for the payment of these professional services.

Signature_

Date_

Acknowledgment of Privacy and Voluntary Consent Form

In providing services to you, we create, receive, and store health information that identifies you. It is often necessary to use and disclose this information to treat you and conduct healthcare operations involving our office. The *Notice of Privacy Practices* posted in our office describes these uses and disclosures in detail. Please refer to this notice any time prior to signing this Consent Form. Copies are available for your personal documents. I have read this Receipt and Consent Form and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare options.

Signature

If you are signing as a personal representative of the patient, please indicate your relationship to the patient and print your name.

Relationship to patient

Print Name