

Social History

BMI info: Height _____ ft. _____ in. Weight _____ lbs. Race/ Ethnicity _____

Tobacco use? Yes NoAre you pregnant? Yes No Breast 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: None known Penicillin Sulfa drugs Other: _____ Check this box if NO medical conditions apply. Otherwise (Please check all that apply in each box)

Constitutional <input type="checkbox"/> None <input type="checkbox"/> Weight loss <input type="checkbox"/> Fatigue <input type="checkbox"/> Trauma <input type="checkbox"/> Fever <input type="checkbox"/> Cancer	Neurological <input type="checkbox"/> None <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Epilepsy <input type="checkbox"/> Headaches <input type="checkbox"/> Seizures <input type="checkbox"/> Migraines	Gastrointestinal <input type="checkbox"/> None <input type="checkbox"/> Acid Reflux <input type="checkbox"/> Colitis <input type="checkbox"/> Ulcer <input type="checkbox"/> Crohn's disease
Allergic/Immunologic <input type="checkbox"/> None <input type="checkbox"/> Drug Allergy <input type="checkbox"/> Environmental Allergy <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Lupus	Endocrine <input type="checkbox"/> None <input type="checkbox"/> Type 1 Diabetes <input type="checkbox"/> Type 2 Diabetes <input type="checkbox"/> Thyroid disorders <input type="checkbox"/> Hormonal dysfunction	Musculoskeletal <input type="checkbox"/> None <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Muscular Dystrophy <input type="checkbox"/> Osteoarthritis
Cardiovascular <input type="checkbox"/> None <input type="checkbox"/> Heart disease <input type="checkbox"/> Stroke <input type="checkbox"/> Vascular disease <input type="checkbox"/> High Blood Pressure/HTN <input type="checkbox"/> High Cholesterol	Blood/Lymphatic <input type="checkbox"/> None <input type="checkbox"/> Anemia <input type="checkbox"/> Leukemia <input type="checkbox"/> Bleeding disorders	Integumentary/Skin <input type="checkbox"/> None <input type="checkbox"/> Eczema <input type="checkbox"/> Rosacea <input type="checkbox"/> Psoriasis <input type="checkbox"/> Skin Cancer
Genital, Kidney, Bladder <input type="checkbox"/> None <input type="checkbox"/> Urinary Tract Infection <input type="checkbox"/> Kidney concerns <input type="checkbox"/> STD: Herpes, Chlamydia, etc. <input type="checkbox"/> HIV	Psychiatric <input type="checkbox"/> None <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Insomnia	Respiratory <input type="checkbox"/> None <input type="checkbox"/> Asthma <input type="checkbox"/> Bronchitis <input type="checkbox"/> Emphysema <input type="checkbox"/> COPD
Ears, Nose & Throat <input type="checkbox"/> None <input type="checkbox"/> Upper Respiratory Tract Infection <input type="checkbox"/> Sinus	<input type="checkbox"/> Premature at birth	<input type="checkbox"/> 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 _____