Patient Information

Patient Name: _____

Patient DOB: _____

Patient SS#: _____

Patient Address: _____

Patient Home Phone: ( )_____

Work: ( )_____

Cell: ( )_____

Email Address: _____

Emergency Contact Name: _____

Number: ( )_____

How did you hear about us? *(check ALL that apply)*

- **Family/Friend**
- **Online**
- **Dr.** _____

To evaluate the health of the retina, please choose one of the following:

- **Optomap Retinal Images** *This technology helps the doctor better detect ocular and systemic diseases such as diabetes, high blood pressure, and high cholesterol.* ***Optomap imaging does NOT have side-effects such as blurry vision and light sensitivity since no medications are used.***
- **Dilating Drops** *Dilating drops are used to dilate or enlarge the pupils of the eye to allow the optometrist 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. They may also make bright lights bothersome. It is not possible for your optometrist to predict how much your vision will be affected. Driving may be difficult immediately after an examination, so it is best if you make arrangements not to drive yourself when you leave our office. If your child is dilated, he/she will have difficulty in completing schoolwork and homework. In addition, he/she should not participate in contact sports on the day of dilation. Like other medications, dilation drops may have side effects or cause allergic reactions.

I hereby authorize the doctors at Precision Optometric Care to administer dilating drops. I understand that eye drops are necessary to diagnose my condition and/or examine my eyes and that dilating drops may be put into my eyes each time I am examined or treated at Precision Optometric Care.

Signature for consent to drops: _____***Date:*** _____

HIPAA: Notice of Privacy Practices

I acknowledge, by my signature below, that I have been given the opportunity to review the Notice of Privacy Practices, and I understand that I may request a copy of this notice should I so choose. I agree to electronic communication of appointment reminders as indicates above and outlines in the Notice of Privacy Practices.

Patient or Guardian Signature: _____ **Date:** _____

Ocular History:

Eye Conditions - Have you ever been diagnosed with any of the following conditions?

Cataract	Yes	No	Eye infection, inflammation, allergy	Yes	No
Macular Degeneration	Yes	No	Floaters and/or flashes of light	Yes	No
Glaucoma	Yes	No	Iritis or Uveitis	Yes	No
Diabetic Retinopathy	Yes	No	Retina defects or degenerations	Yes	No
Dry Eye	Yes	No			

Please mention any additional conditions: _____

Eye/Vision Concerns - Are you having any of the following concerns?

Redness	Yes	No	Eyepain	Yes	No
Burning	Yes	No	Severe Sensitivity to lights	Yes	No
Itching	Yes	No	Headache	Yes	No
Tearing	Yes	No	Poor night vision	Yes	No
Discharge	Yes	No	Bothersome night glare	Yes	No
Blurred Vision	Yes	No	Double vision	Yes	No
Eyestrain	Yes	No	Total loss of vision	Yes	No

Please mention any additional eye/vision concerns: _____

Medical History:

List any medications you are currently taking (include oral contraceptives, aspirin, over the counter medications):

_____

Are you allergic to any medications? Yes No If yes, which ones: _____

Review of Systems:

Please check the box beside any problem you currently have, or have had, in the following areas

Allergic / Immunologic All normal
- Allergy / Hay Fever

Cardiovascular / Cardiac All normal
- Arteriosclerosis
- Heart Disease
- High Blood Pressure
- High Cholestrol

Constitutional All normal
- Fever
- Weight Loss / Gain

Ears, Nose, Mouth, Throat All normal
- Sinus Congestion
- Dry Throat / Mouth

Endocrine All normal
- Diabetes
- Thyroid Disease
- Chronic Fatigue

Gastrointestinal All normal
- Diarrhea / Constipation
- IBS / Crohn's Disease
- Ulcers
- Reflux

Genitourinary All normal
- Kidney
- Ovarian / Uterine Cancer
- Prostate Cancer

Hematologic / Lymphatic All normal
- Anemia
- Bleeding Problems
- Breast Cancer

Integumentary (Skin) All normal
- Cancer
- Rashes
- Easy Bruising

Musculoskeletal All normal
- Rheumatoid Arthritis
- Muscle Pain
- Joint Pain

Neurological All normal
- Migraines
- Dizziness
- Seizures
- Stroke

Psychiatric All normal
- Anxiety
- Depression
- Memory Loss
- Hallucinations

Respiratory All normal
- Asthma
- Bronchitis
- Emphysema
- Chronic Cough

Women who are pregnant or nursing, specify below:
- Pregnant
- Nursing

Patient or Guardian Signature: _____ **Date:**_____

Insurance Information:

Do you plan on using insurance?

- **Yes** *(Please provide ID and Insurance card)*
- **No** *(All self pay balances must be paid off on the day of service)*

Person responsible for payment:

Name: _____

Address: _____

Home Phone: ( )_____

Work: ( )_____

Cell: ( )_____

Medical Insurance: _____ **Vision Insurance:** _____

Subscriber's Name: _____

DOB: _____

SS#: _____

Insurance ID#: _____

Cancellation/ No Show Policy:

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book. ***If an appointment is not cancelled at least 24 hours in advance you will be charged a forty dollar ($40) fee; this will not be covered by your insurance company.***

Account balances:

We will require that patients with self pay balances do pay their account balances to zero (0) prior to receiving further services by our practice.

Patient or Guardian Signature: _____ **Date:**_____