Name: _____ Date: ____/____/____
Last first MI

Address: _____
Street City State Zip Code

Telephone # (home) _____-_____-_____ (work) _____-_____-_____ (cell) _____-_____-_____

Occupation_____ SSN: _____ E-mail _____

Circle: Male Female ETHNICITY: Caucasian Hispanic African-American Asian
Other_____

Date of Birth _____/_____/_____ Last Eye Exam _____/_____ Last Medical Exam _____/_____

HOW DID YOU HEAR ABOUT OUR OFFICE?

MEDICAL INSURANCE Primary: Secondary:	VISION INSURANCE
REASON FOR TODAY'S VISIT	

Do you wear glasses? Y N Do you wear contact lenses? Y N If yes, are they comfortable? Y N
Do you sleep in your contacts? Y N If yes, how many nights in a row?__ Are you willing to try a daily disposable? Y N

CURRENT EYE PROBLEMS	Yes	No
Burning/Sandy/Gritty Feeling	○	○
Itching	○	○
Excess Tearing/Watering	○	○
Flashing lights	○	○
Floaters or Spots	○	○
Dryness	○	○
Redness	○	○
Eye Pain or Soreness	○	○
Foreign Body Sensation	○	○
Infection of Eye or Lid	○	○
Glare/Light sensitivity	○	○
Mucous Discharge	○	○
Headaches	○	○

CURRENT EYE PROBLEMS	Yes	No
Blurred vision distance/near	○	○
Drooping Eyelid	○	○
Distorted Vision (halos)	○	○
Double Vision	○	○
Fluctuating Vision	○	○
Loss of Vision/Side Vision	○	○
Glaucoma	○	○
Cataract	○	○
Macular Degeneration	○	○
Retinal Detachment	○	○
Lazy eyes/crossed eyes	○	○
Eye surgeries	○	○

Other_____

MEDICAL HISTORY	Yes	No
Diabetes	○	○
High Blood Pressure	○	○
Thyroid	○	○
Respiratory (Asthma)	○	○
Gastrointestinal	○	○
Kidney	○	○
High Cholesterol	○	○

List any medications you are taking:
_____
_____

MEDICAL HISTORY	Yes	No
Skin (Eczema, Rosacea)	○	○
Neurological (MS)	○	○
Anxiety, Depression	○	○
Muscles, Bones, Joints	○	○
Ears, Nose, Throat	○	○
Blood/Lymph	○	○
Allergic/Immunologic	○	○
Heart disease	○	○

Other:_____
_____

FAMILY HISTORY	Yes	No
Lazy Eye	○	○
Blindness	○	○
Cataracts	○	○
Color Blindness	○	○
Glaucoma	○	○
Macular Degeneration	○	○

	Yes	No
Retinal Detachment	○	○
Eye Turn	○	○
Arthritis	○	○
Cancer	○	○
Diabetes	○	○
Heart Disease	○	○

	Yes	No
High Blood Pressure	○	○
Kidney Disease	○	○
Lupus	○	○
Strokes	○	○
Thyroid	○	○

SOCIAL HISTORY

	Yes	No	
Do you use tobacco products?	○	○	If yes, type/amount/how long _____
Do you drink alcohol?	○	○	If yes, type/amount/how long _____

TURN OVER

Do you use recreational drugs? ○ ○ If yes, type/amount/how long _____
Do you have any allergies to medications? _____

REGARDING INSURANCE:
We do not participate in all vision or medical plans. It is your responsibility to provide us with your insurance information when you make the appointment and/or arrive for your appointment. Most insurance companies require pre-authorization. If you do not provide this information upon arrival, then you are responsible for all fees, deductibles, co-pays and any extras not covered by your insurance. All payments are due at the time of your appointment because we do not routinely bill or mail statements.

PUPIL DILATION

Pupil dilation is an important and strongly recommended test. It requires the doctor to instill eye drops to keep the pupil open and get a better view of the structures of the back of the eyes.
This test is used to evaluate eye diseases such as:
1) cataracts 2) glaucoma 3) tumors 4) retinal detachment
This test is required for patients who have:
1) diabetes 2) hypertension 3) a strong prescription 4) any known eye disease
Side effects usually last 2-4 hours and include:
1) sensitivity to light 2) blurry vision at near 3) possible distant blur

Driving is usually not impaired; however, you should schedule the dilation for another day if you feel uncomfortable operating a vehicle under these conditions.

The fee for DILATION is $55.00

Please indicate your preferences:

_____ I would prefer my eyes dilated today.
_____ I decline dilation, understanding that a condition with a potential for vision loss may go undetected.

Patient/Parent signature _____ Date_____

When was the date of your last pupil dilation exam?_____
——

HIPAA PRIVACY

I authorize this office to 1) perform its administrative duties 2) provide me with eye care services and products 3) process my vision benefit claims ad 4) communicate with me regarding vision care services provided. I understand this will involve disclosure of the necessary personal information to another party; however, this office will not sell my personal health information of any kind to any third party for such party's own use.
Patient/Parent signature_____ Date_____
——-

CONTACT LENS POLICY

Contact lenses are medical devices. New Jersey state law mandates that at least one follow up visit is required after the initial exam to evaluate the contact lenses. Should you need more than TWO follow up visits, it will be at the Doctor's discretion to charge for a follow up visit which is $25.00

All follow up visits need to be completed within TWO months (8 weeks) of the initial exam.
A fee of $25 will be charged if the follow up visit is between 2-4 months.
A fee of $50 will be charged if the follow up visit is between 5-6 months.
A new contact lens exam will be required after 6 months and FULL fee for the exam will be charged.

Patient/Parent signature _____Date_____

TURN OVER