Patient Name: (Last, First)____Date: ____/____/____
Last First MI

(if patient is younger than 18 years old, please include parent/guardian name in parenthesis)

Address: ____
Street City State Zip Code

Telephone # (home) ______-________-________ (work) ______-________-________ (cell) ______-________-__________

Occupation__________________________ SSN: ______________________ E-mail:________________________________

Circle: Male Female Other* ETHNICITY: Caucasian Hispanic African-American Asian
Date of Birth ______/______/______ Last Eye Exam ______/______ Last Medical Exam ______/________

Insurance Holder's Name: ____ Date of Birth ______/______/______
Last First MI

MEDICAL INSURANCE**:	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	**CURRENT EYE PROBLEMS**	Yes	No
Burning/Sandy/Gritty Feeling	○	○	Blurred vision distance/near	○	○
Itching	○	○	Drooping Eyelid	○	○
Excess Tearing/Watering	○	○	Distorted Vision (halos)	○	○
Flashing lights	○	○	Double Vision	○	○
Floaters or Spots	○	○	Fluctuating Vision	○	○
Dryness	○	○	Loss of Vision/Side Vision	○	○
Redness	○	○	Glaucoma	○	○
Eye Pain or Soreness	○	○	Cataract	○	○
Foreign Body Sensation	○	○	Macular Degeneration	○	○
Infection of Eye or Lid	○	○	Retinal Detachment	○	○
Glare/Light sensitivity	○	○	Lazy eyes/crossed eyes	○	○
Mucous Discharge	○	○	Eye surgeries	○	○
Headaches	○	○	Other_________________________________		

MEDICAL HISTORY	Yes	No	**MEDICAL HISTORY**	Yes	No
Diabetes	○	○	Skin (Eczema, Rosacea)	○	○
High Blood Pressure	○	○	Neurological (MS)	○	○
Thyroid	○	○	Anxiety, Depression	○	○
Respiratory (Asthma)	○	○	Muscles, Bones, Joints	○	○
Gastrointestinal	○	○	Ears, Nose, Throat	○	○
Kidney	○	○	Blood/Lymph	○	○
High Cholesterol	○	○	Allergic/Immunologic	○	○
List any medications you are taking:			Heart disease	○	○
____			Other:__________________________________		

FAMILY HISTORY	Yes	No		Yes	No		Yes	No
Lazy Eye	○	○	Retinal Detachment	○	○	High Blood Pressure	○	○
Blindness	○	○	Eye Turn	○	○	Kidney Disease	○	○
Cataracts	○	○	Arthritis	○	○	Lupus	○	○
Color Blindness	○	○	Cancer	○	○	Strokes	○	○
Glaucoma	○	○	Diabetes	○	○	Thyroid	○	○
Macular Degeneration	○	○	Heart Disease	○	○			

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 ___________________________________
Do you use recreational drugs?	○	○	If yes, type/amount/how long ___________________________________

Do you have any allergies to medications? ____

IMPORTANT – PLEASE READ! PUPIL DILATION vs. DIGITAL RETINAL IMAGE

In the past pupil dilation required 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 was used to evaluate eye diseases such as: cataracts, glaucoma, tumors and retinal detachments and is required for patients who have diabetes, hypertension, a strong prescription or any known eye disease. The test takes about 45 minutes to complete. Side effects usually last 2-4 hours and include: sensitivity to light and blurry vision. Driving is usually not impaired; however, you should schedule the dilation for another day if you feel uncomfortable operating a vehicle under these conditions.

Insight Eyecare now offers **digital retinal imaging**, a more comprehensive and convenient solution: the Clarus 500 Ultrawide Field Camera. This device takes a high-definition picture of the back of your eye and gives the doctor much more information than a traditional dilation. It takes only about 5 minutes, has no side effects, and typically requires just a copay of **$39** or $**55** depending on your insurance.

Is digital retinal imaging better than dilation?

Dilation only allows the doctor to see about 15% percent of your retina. With digital retinal imaging, that number increases by about 80%. This means more accurate diagnoses and a better understanding of your health.

Please indicate your preference:

_____I would prefer the Clarus Fundus Camera Image ($39-$55 copay)

_____I would prefer my eyes dilated with traditional drops. I understand that I would have to come back on another day.

_____I decline all dilation or images, 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?________________

CONTACT LENS POLICY

Contact lenses are considered **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_________________________

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________________

*REGARDING GENDER:

This information is required for communicating with your insurance company. We also use it for medical reference. Some eye disorders are more common in males than females, for example. If you would like to provide more details on your gender identity, including preferred pronouns, you may use the space below. This information will not be shared outside this office. Insight Eyecare is committed to making sure every patient feels welcome and respected.

**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.