PATIENT INFORMATION:

Patient name (last, first):_____Occupation_____

Address:_____City:_____State:_____Zip:_____

Home Phone:_____Cell Phone:_____Date of Birth:_____Age:_____Sex: M or F

Last 4# SSN:_____Employer:_____Work phone:_____

Email:_____ Marital status: Married Single Widowed Minor

How did you hear about us?_____

Vision Insurance:_____Insured's Name:_____Insured's DOB_____

Insured's Address:_____ Insured's ID number_____

Medical Insurance: ( ) Medicare ( )Medicaid Other:_____

Policy holder's name:_____Insured's DOB_____ ID number_____

Relationship to patient:_____Address (if different from above):_____

WELLNESS SCREENING OCT/ PHOTO SCAN:

This wellness screening scan uses a highly advanced 3D camera which utilizes both optical coherence tomography (OCT) and retinal photography to produce a digital photograph and a 3D cross section of the back of your eye simultaneously. This scan can detect potentially serious conditions such as glaucoma, macular degeneration, diabetic eye problems, vitreous detachments, and many other sight threatening problems, in many cases BEFORE signs and symptoms occur.

This scan is non-invasive, painless, and can be completed in 60 seconds or less. Most of the time quality scans are achieved without having to dilate your eyes, in some cases a mild dilating drop may be used. These scans are great for baseline eye health and can be used for future exams to monitor disease progression. The doctor recommends EVERY patient 18 years or older to have this done, especially if there is a family history or if the patient has any of the eye conditions mentioned above. Insurances do not cover wellness scans for screening purposes. **THE FEE FOR THIS PROCEDURE IS $39.00**

DILATION :

Dilating the pupil with eye drops will allow the doctor to achieve a better view inside the eye to help detect various eye problems otherwise unseen. Most dilating drops we use will temporarily blur your vision for about an hour, but some patients can have vision effects that last longer than 4 hours. Therefore, we recommend you have a driver if you have not had it done before.
It is strongly recommended that all patients receive this procedure that have diabetes, high nearsightedness or are experiencing flashes of lights or floaters in their vision. There is no additional fee for dilation if performed on the same day of your exam.

PLEASE CHOOSE ONE/ OR BOTH OF THE FOLLOWING: (IF NOTHING IS SELECTED IT WILL BE THE SAME AS DECLINING BOTH PROCEDURES)

_____ I WOULD LIKE TO RECEIVE THE **WELLNESS SCREENING OCT/ PHOTO SCAN ($39.00)**

_____ I WOULD LIKE TO RECEIVE **DILATION**

_____ I DO NOT WANT THE WELLNESS SCREENING OR DILATION—By declining I understand the doctor will be limited to the view achieved inside the eye and may not be able to detect potential problems that could lead to permanent loss of vision.

Patient/ Guardian signature_____
(If minor, parent or guardian must sign)

Patient or Guardian printed name:_____ Date:_____

PAST, FAMILY, AND SOCIAL HISTORY:

Current medications: NONE or_____

Allergies to medications or materials: NONE or_____

Have you ever had or have any of the following (circle if yes): NONE Glaucoma Retinal Detachment Macular Degeneration
Dry Eyes Lazy Eye Blindness Crossed eyes
Cataracts Lasik surgery Cataract surgery Other eye surgery

Have you been diagnosed with or have had any of the following: NONE Diabetes Type I / Type II High Cholesterol COVID-19
High Blood Pressure/Hypertension Cancer: type_____

Family Eye History: NONE Glaucoma Macular Degeneration Blindness Cataracts Other_____

Family Medical History: NONE OF THESE Diabetes Type I Diabetes Type II High Blood Pressure/ Hypertension

Social History: Occupation:_____ Pregnant or Nursing? Yes No

Ever been infected with any of the following: NONE Syphilis TB Gonorrhea Hepatitis HIV

Use any of the following? Tobacco N Y Type/Amt/ HowLong:_____
Alcohol N Y Type/Amt/HowLong:_____
Rec. Drugs N Y Type/Amt/HowLong:_____

Do you currently wear glasses? Yes No
Do you currently wear contacts? Yes No
Do you want to be fit for a contact lens RX today? Yes No Have you worn them before? Yes No
What brand do you currently wear? _____
What is your current contact lens RX? Right)_____Left)_____

Race (optional): _____Ethnicity (optional):_____

Preferred Language: English Spanish Other_____

REVIEW OF SYSTEMS: Please circle any condition that applies to you. (Circle "NONE" by each system that is normal)

GENERAL:	NONE	Weight gain Fatigue Weight loss Fever
ALLERGIC/ IMMUNO:	NONE	Seasonal allergies Food allergies Hay fever Lupus R.A
CARDIOVASCULAR:	NONE	High BP/Hypertension Vascular disease Surgery Stroke
EAR, NOSE, TROAT:	NONE	URI Sinus problems Chronic cough Dry throat/ mouth Hard of hearing
ENDOCRINE:	NONE	Diabetes I Diabetes II Hyperthyroid Hypothyroid Hormone Dysfunction
EYE:	NONE	Glaucoma Glau. Suspect Cataract Mac. Degen. Lasik Dry Eye
GASTROINTESTINAL:	NONE	Chrons Colitis Ulcer Constipation Diarrhea
GEN., KID., BLADDER:	NONE	STD Kidney problems Bladder problems
BLOOD/ LYMPH:	NONE	High Cholesterol Anemia Swelling Bleeding Leukemia
SKIN:	NONE	Eczema Rosacea Psoriasis Acne
MUSCULOSKELETAL:	NONE	Fibromyalgia Arthritis AnklSpondylitis Mus.Dystrophy
NEUROLOGICAL:	NONE	Epilepsy M.S. Headaches Migraines Seizures
PSYCHIATRIC:	NONE	Anxiety Depression Insomnia
RESPIRATORY:	NONE	COPD Asthma Bronchitis Emphysema

Date of last eye exam:_____ Place of last eye exam:_____

Date of last physical exam:_____ Name of Primary Care Physician:_____

Patient signature (If minor parent/ guardian must sign):_____

(Please Print Patient Name:)_____

(Please Print parent/ guardian name if applicable:)_____ Date:_____