WELCOME TO EXQUISITE EYE CARE

PATIENT INFORMATION

Thank you for choosing our practice for your eye-care needs.

Please complete this form **(3** *pages***)** *in ink. If you have any questions or concerns, do not hesitate to ask. We will be happy to assist you in any way.*

(PLEASE PRINT) *Date*_____

*Name*_____ _____ _____
(Mr., Mrs., Ms., Dr.) First MI Last Nickname Social Security No.

Address _____ *Apt. No.*_____ *City* _____

State _____*Zip* _____*Home Phone No.*_____ *Work Phone No.* _____ *Ext,* _____

Date of Birth _____ *Age* _____ *Sex* _____ *Occupation* _____
(MM/DD/YYYY) (M/F)

Employer/School _____ *Hobbies* _____

Referred by: Family □ Friend □ Doctor □ Yellow Pages □ Ad □ Coupon □ Walk-in □ Recall Letter □ Newspaper □ Other _____

RESPONSIBLE PARTY

Name of Person Responsible for account _____

Relationship to Patient _____ *Contact Phone No.* _____

*Address*_____ *Apt. No.* _____ *City* _____

State _____ *Zip* _____ *Employer* _____ *Work Phone No.* _____ *Ext.* _____

Drivers License No _____ *Method of Payment: Cash □ Check □ Visa □ MasterCard □ Discover □*

VISION INSURANCE INFORMATION

Name of Insurance Plan _____ *Group Number*_____

Name of Insured _____ *Relationship to Patient* _____

Date of Birth Of insured _____ *Insured's Social Security or Member ID number* _____

IMPORTANT HEALTH HISTORY

*Reason for today's exam*_____ *Date of Last Exam* _____

Name of last eye doctor _____

Please List all surgeries _____

Please list all drug allergies _____

_____

Please List all medications you are currently taking _____

_____

Please continue on next pg →

Review of Symptoms-Please check all that apply to you:

Eyes

Blindness	❒ Y	❒ N
Loss of vision	❒ Y	❒ N
Distorted Vision	❒ Y	❒ N
Blurred vision	❒ Y	❒ N
Double Vision	❒ Y	❒ N
Cataracts	❒ Y	❒ N
Flashes or floaters	❒ Y	❒ N
Dry Eyes	❒ Y	❒ N
Watery Eyes	❒ Y	❒ N
Red eyes	❒ Y	❒ N
Mucus Discharge	❒ Y	❒ N
Burning or itching	❒ Y	❒ N
Sandy or gritty feeling	❒ Y	❒ N
Eye pain or soreness	❒ Y	❒ N
Glare/Light sensitivity	❒ Y	❒ N
Chronic Eye infections	❒ Y	❒ N
Crossed Eyes	❒ Y	❒ N
Tired Eyes	❒ Y	❒ N
Halos	❒ Y	❒ N
Vision Therapy	❒ Y	❒ N
Eye surgery	❒ Y	❒ N
Retinal Detachment	❒ Y	❒ N
Glaucoma	❒ Y	❒ N

Personal Medical History

Allergies		
Hay Fever	❒ Y	❒ N
Medicine Allergies	❒ Y	❒ N
Cardiovascular		
Heart Pain	❒ Y	❒ N
High Blood Pressure	❒ Y	❒ N
Vascular disease	❒ Y	❒ N
Ears, Nose, Mouth, Throat		
Sinus Problems	❒ Y	❒ N
Chronic cough	❒ Y	❒ N
Dry Throat/ Mouth	❒ Y	❒ N
Chronic Ear Infection	❒ Y	❒ N
Endocrine		
Thirsty all the time	❒ Y	❒ N
Frequent Urination	❒ Y	❒ N
Diabetes	❒ Y	❒ N
Thyroid Problems	❒ Y	❒ N
Gastrointestinal		
Diarrea	❒ Y	❒ N
Constipation	❒ Y	❒ N
Ulcers	❒ Y	❒ N
Genitourinary		
Genitals	❒ Y	❒ N
Kidneys	❒ Y	❒ N
Bladder	❒ Y	❒ N

Personal Medical History

Hematological		
Anemia	❒ Y	❒ N
Bleeding problems	❒ Y	❒ N
Integument		
Skin	❒ Y	❒ N
Breast	❒ Y	❒ N
Musculoskeletal		
Arthritis	❒ Y	❒ N
Rheumatoid Arthritis	❒ Y	❒ N
Muscle Pain	❒ Y	❒ N
Neurological		
Headaches	❒ Y	❒ N
Migraines	❒ Y	❒ N
Seizures	❒ Y	❒ N
Psychiatric		
Nervous Disorders	❒ Y	❒ N
Depression	❒ Y	❒ N
Compulsive Behavior	❒ Y	❒ N
Respiratory		
Asthma	❒ Y	❒ N
Shortness of Breath	❒ Y	❒ N
Emphysema	❒ Y	❒ N
Lung Cancer	❒ Y	❒ N
Constitutional Symptoms		
Fever	❒ Y	❒ N
Weight loss	❒ Y	❒ N

Does anyone in the family have a history of the following?

□ Cataracts□ Thyroid □ Arthritis □ Blindness □ Turned or lazy eye □ High Blood Pressure □ Glaucoma □ Heart Condition □ Diabetes

Please check any of the following that apply to you:

□ Frequent Headaches □ Allergies □ Pregnant □ Sinus Trouble □ Drug allergies □ Given birth in the last 6 months

Do you currently wear glasses? □ Y □ N Do you work at a computer or video display terminal**?** □ Y □ N If yes how many hours? _____

When do you wear your glasses?

□ All the time □ Reading/Near work □ Work Safety □ distance task only □ Computer work

□ Other (please explain) _____

Have you ever worn contacts? □ Y □ N Are you interested in wearing contact lenses? □ Y □ N

If so, what brand _____ or □ Unsure

If so what style (check all that apply) □ Soft □ Gas Permeable (RGP) □ Bifocal □ Progressive □ Disposable
□ Conventional □ Extended wear □ Toric □ Clear □ Color
□ Unsure

PUPIL DILATION/FUNDUS PHOTO

Dilation of the pupil is now considered a standard procedure in a comprehensive eye examination. Dilating drops enlarge the size of the pupil (the center black spot of the eye) and allow the doctor a more thorough examination of the retina (back of the eye). Dilation assists in detection of glaucoma, cataracts, diabetic and hypertensive retinal change, retinal hole, tears, and detachment as well as some types of tumors. The side effects are light sensitivity and trouble focusing up close. Even though the side effect lasts about 3 to 5 hours, you should be able to drive home. However, you do have the option to have the fundus photo done which will have no side effects. The cost of the fundus photo is $30.00.

Pupil Dilation: □ Yes □ No □ Discuss with doctor
Fundus Photo: □ Yes □ No □ Discuss with doctor

PERIMETER TEST (Visual Fields)

A perimeter test is performed to detect any form of visual (peripheral) field loss. Visual field abnormalities may occur due to disease or disorders of the eye, optic nerve, or brain. Some conditions may include glaucoma, diabetes, macular degeneration, retinal abnormalities, double vision, color vision abnormalities, and certain types of tumors. The cost of a Perimeter test is **$30.00.**

Perimeter Test: □ Yes □ No □ Discuss with Doctor

Fundus Photo and Perimeter Package: $50 □ Yes □ No
(Save $10)

Exquisite Eye Care

ACKNOWLEDGMENT OF RECEIPT

I acknowledge that I have received a copy of Exquisite Eye Care Notice of Privacy Practices.

Patient Name _____

Signature _____ Date _____

I acknowledge that I have been given the following options related to communicating with Exquisite Eye Care, its doctors and staff members:

I agree to allow Exquisite Eye Care doctors and staff to leave messages on my answering machine, answering service or with an individual at my home or workplace that identifies the message as originating from Exquisite Eye Care. I understand that clinical information will not be part of this message.

Please circle one of the following:

Yes, I agree **No, I do not agree**

I agree to allow Exquisite Eye Care to send me marketing materials/ clinical information concerning services that may contain my name and that of Exquisite Eye Care and/or an individual optometrist or ophthalmologist providing care at Exquisite Eye Care.

Please circle one of the following:

Yes, I agree **No I do not agree**

Assignment & Release/Services & Materials Rendered: I hereby authorize my insurance benefits to be paid directly to the physician and understand that I am financially responsible for non-covered services. I authorize the physician to release information required to process this claim. I also acknowledge that if I am not using insurance benefits, payment is expected in full at time of services and/or materials rendered.

Signature of responsible party: _____