

# WELCOME TO OUR OFFICE

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY / STATE / ZIP: \_\_\_\_\_

DAY PHONE: \_\_\_\_\_ EVENING / CELL PHONE: \_\_\_\_\_

BIRTH DATE: \_\_\_\_\_ SOCIAL SECURITY #: \_\_\_\_\_

HEALTH INSURANCE: \_\_\_\_\_ PRIMARY INSURED: \_\_\_\_\_

RELATIONSHIP TO INSURED: MEMBER SPOUSE CHILD PRIMARY INSURED BIRTH DATE: \_\_\_\_\_

PRIMARY INSURED ADDRESS: \_\_\_\_\_ CITY / STATE / ZIP: \_\_\_\_\_

PRIMARY INSURED SOCIAL SECURITY: \_\_\_\_\_ LAST EYE EXAM: \_\_\_\_\_

HOW WERE YOU REFERRED TO US? \_\_\_\_\_ PREVIOUS PATIENT? YES NO

EMAIL: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_

**DILATION PROCEDURE:** Dilation includes the use of topical medications to dilate the pupil of the eye, to detect disease such as glaucoma, retinal detachments, malignant growths, diabetic retinopathy, hypertensive retinopathy, etc... Having your pupils dilated is a painless procedure with some minor side-effects. These include: mild burning on installation of drops, sensitivity to light, inability to focus at near, and blurry distance vision for some patients. These side effects usually last no longer than 4 to 5 hours. Some patients find it difficult to drive, and thus must bring a driver with them. State law requires that all certified Optometrists must perform a dilated exam on:

- All new patients to our practice.
- All established patients who have previously not been dilated.
- All established patients who were previously dilated but deemed medically necessary to be again.

Dr. Fowler will do a dilated eye exam. If you find it inconvenient to have your eyes dilated at this visit, or wish not to have your eyes dilated, please indicate.

I understand the importance of having my eyes dilated and understand the possible side effects.

At this time (PLEASE INITIAL):

\_\_\_\_\_ YES, I agree to allow dilation.

\_\_\_\_\_ I would prefer to NOT have a dilated eye exam.

\_\_\_\_\_ I would prefer to RE-SCHEDULE the dilation procedure. \* There will be a \$30.00 charge for this visit.

**ASSIGNMENT, RELEASE, AND OFFICE POLICY:** I hereby authorize the physician to release any information required to process a health insurance claim. I also authorize my insurance benefits to be paid directly to the physician and I understand that I am financially responsible for all non-covered services. I authorize health insurance plans to be billed for medical exams. I understand that all fees and charges are final. This includes contact lens fitting fees. Refunds/exchanges will not be issued. Therefore, payment delay, dispute, and withholding will not occur. I will be responsible to pay any attorney, collection, and related fees should collection occur.

PATIENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**NOTICE OF PRIVACY POLICY (HIPAA):** I have received a copy of the Notice of Privacy Practices and I have read this consent and understand it. I understand that I have the right to restrict the use and disclosure of my health information. By signing below I consent to the use or disclosure of my health information for treatment, payment, and to conduct health care operations involving this office or related health care facilities.

PATIENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

Please check each item Yes or No as they relate to your health.

		Yes	No			Yes	No			Yes	No
<b>EYES</b>			<b>ENDOCRINE</b>			<b>NERVOUS SYSTEM / BRAIN</b>					
Double Vision			Diabetes - Type I or Type II			Seizures / Epilepsy					
Pain			<i>How long?:</i>			Numbness					
Floaters or Spots			Thyroid			Stroke - <i>When:</i>					
Seeing Flashes of Light						Alzheimer's					
Dry Eyes			<b>CANCER</b>								
Decreased Vision			Location:			<b>PSYCHIATRIC</b>					
Sandy/Gritty Feeling			Radiation <input type="checkbox"/> Chemotherapy <input type="checkbox"/>			Anxiety / Depression					
Excessive Tearing						Mood Swings / Difficult Sleep					
			<b>GENERAL HEALTH</b>								
<b>BLOOD / LYMPH</b>			Weight Loss			<b>KIDNEY / BLADDER / URINARY</b>					
Anemia			Fatigue			Prostate					
Easy Bruising			Fever			Urination Difficulty					
Prolonged Bleeding						Bladder					
Use Blood Thinners?			<b>STOMACH/ INTESTINES</b>			Kidney-Dialysis					
			Stomach Problems			Dialysis - # of times: <i>wk</i>					
			Liver Problems								
<b>MUSCULOSKELETAL</b>						<b>EAR, NOSE, MOUTH, THROAT</b>					
Arthritis			<b>CARDIOVASCULAR</b>			Hearing - Loss / Problems					
<b>ALLERGIC / IMMUNOLOGIC</b>			Murmur			Mouth (dentures)					
Hay Fever			Chest Pain / Angina			Sinus					
			Palpitations								
<b>LUNGS / RESPIRATORY</b>			Heart Attack -			<b>SKIN</b>					
Cough			<i>When:</i>			Skin Rashes					
Wheezing			High Blood Pressure			Ulcers					
Emphysema			Hand or Ankle Swelling			Swelling					
Asthma											

**PAST MEDICAL / SURGICAL HISTORY:**

List your other illnesses not listed above	List your past Surgeries	Date

Married  Widowed  Single  Divorced Number of Children: \_\_\_\_\_

Non-Smoker  Smoker - # of packs per day? \_\_\_\_\_  No Alcohol  Alcohol - Number of drinks per day? \_\_\_\_\_

**Family/Social History:** Check Self of No as related to your family history. Explain positive responses ie: Mother, Father, Sister, Brother, Grandparents

	Self	No	Family Member		Self	No	Family Member
Glaucoma				Diabetes			
Cataract				Hypertension			
Retinal				Vascular			
Macular Degeneration				Cancer			

Drug Allergies: \_\_\_\_\_

Other Allergies: \_\_\_\_\_

Medication Name:

Medication Name:

_____	Rx	OTC
_____	Rx	OTC
_____	Rx	OTC
_____	Rx	OTC
_____	Rx	OTC

_____	Rx	OTC
_____	Rx	OTC
_____	Rx	OTC
_____	Rx	OTC
_____	Rx	OTC