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 $35.00**

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 ($35.00)**

_____ 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:**_______________________