NEW PATIENT HISTORY QUESTIONNAIRE

*****PLEASE PROVIDE A COPY OF YOUR MEDICAL INSURANCE CARD AS WELL AS ANY INFORMATION YOU HAVE REGARDING YOUR VISION PLAN*****

TODAY'S DATE: _____

PATIENT NAME: _____ SEX: (M F) DATE OF BIRTH: _____ AGE: _____

ADDRESS: _____

HOME: _____ CELL: _____

OCCUPATION: _____ EMAIL ADDRESS: _____

SOCIAL SECURITY #: _____ EMPLOYER: _____ PHONE: _____

EMERGENCY CONTACT/GUARDIAN: _____ PHONE: _____

REASON FOR TODAY'S VISIT: ☐ NEW GLASSES ☐ NEW CONTACTS ☐ MEDICAL

DATE OF LAST EYE EXAM: _____ NAME EYE DOCTOR: _____

HOW DID YOU HEAR OF US? _____ REFERRED BY: _____

DATE OF LAST MEDICAL EXAM: _____ NAME MEDICAL DOCTOR: _____

PATIENT MEDICAL, SOCIAL AND EYE HISTORY: *PLEASE CIRCLE YOUR RESPONSES*

DO YOU OR HAVE YOU WORN GLASSES? YES NO
IF YES, ☐ FULL TIME ☐ DISTANCE ☐ READING

HAVE YOU WORN CONTACT LENSES? YES NO
IF YES, WHICH BRAND: _____

HAVE YOU HAD AN EYE SURGERY, INJURY, OR INFECTION? DESCRIBE: _____ YES NO

_____

DO YOU HAVE FREQUENT HEADACHES, DOUBLE VISION,OR SENSITIVITY TO BRIGHT LIGHT? YES NO

DO YOU SEE FLASHES OF LIGHT, FLOATERS, VISION LOSS? DESCRIBE: _____ YES NO

LIST YOUR MEDICATIONS: **NONE** **(please circle)**

_____

_____

_____

LIST ANY ALLERGIES *(DRUG, SEASONAL)*: **NONE** **(please circle)**

_____

_____

_____

FAMILY AND PERSONAL HEALTH HISTORY: *PLEASE CIRCLE YOUR RESPONSES*

CONDITION:	***SELF:***		***FAMILY:***		***FAMILY MEMBER: MATERNAL/PATERNAL ?***
ARTHRITIS	YES	NO	YES	NO	_____
CANCER	YES	NO	YES	NO	_____
DIABETES	YES	NO	YES	NO	_____
HEART DISEASE	YES	NO	YES	NO	_____
HIGH BLOOD PRESSURE	YES	NO	YES	NO	_____
STROKE	YES	NO	YES	NO	_____
THYROID DISEASE	YES	NO	YES	NO	_____
CATARACT	YES	NO	YES	NO	_____
GLAUCOMA	YES	NO	YES	NO	_____
MACULAR DEGENERATION	YES	NO	YES	NO	_____
LAZY EYE/EYE TURN	YES	NO	YES	NO	_____
BLINDNESS	YES	NO	YES	NO	_____
SMOKER	YES	NO	YES	NO	_____

DILATION OF THE PUPILS (DFE: DILATED FUNDUSCOPIC EXAMINATION)

Procedure: Dilation eye drops are placed into each eye in order to increase the pupil size for eye health examination

Benefits: Early detection and treatment of eye problems and diseases such as diabetes, high blood pressure, glaucoma, among many others. It gives the best information regarding the most current state of your optic nerve, macula and retinal periphery in order to prevent and treat eye conditions that could lead to vision loss.

Side Effects: Dilation causes light sensitivity to sunlight and blurry vision at near for 4-6 hours. This time frame varies depending on eye color and the type of drops used in office. Most patients have no difficulty with distance vision and driving with these drops. We will provide disposable sunglasses for your comfort.

☐ I Consent to a Dilated Eye Examination ☐ I decline

I have read and I understand the information provided above. If I have chosen to decline the above tests, I understand that I am not allowing the physician to conduct the most thorough examination of the eyes. This will limit the ability to detect eye disease such as retinal detachments, peripheral degenerations, glaucoma, diabetic retinopathy, etc.

SIGN NAME: _____

PRINTED NAME: _____ DATE: _____

HIPAA POLICY AND ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE:

By signing below, I acknowledge that I have received Opticare Vision Centers' Notice of Privacy Practices.

SIGN NAME: _____ DATE: _____

I authorize Opticare Vision Centers to bill my insurance for any vision and/or medical services including materials.
I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered and/or materials by the above office.

SIGN NAME: _____

PRINTED NAME: _____ DATE: _____