EYEDOC VISION SERVICES

Full Name _____ Date of Birth _____ Age ___

Address _____ City, State _____ ZIP _____

Home Phone _____ Cell Phone _____ Work Phone _____

Preferred contact: H / C / W Email _____

Employed/Student/Retired/Not Employed (circle one) Guardian (if minor)_____

Employer/School _____ Occupation _____ Hobbies: _____

INSURANCE INFORMATION: Social Security Number_____

Vision Insurance _____ Vision Insurance ID _____

Medical Insurance _____ Insurance ID/Group # _____

Phone # from ID card _____

Primary Insured: Name _____ Date of Birth _____

Relationship to Patient: Parent/Spouse/Domestic Partner (circle one)

Other family members on insurance plan: _____

Reason for visit today: _____

PAST OCULAR/MEDICAL and SOCIAL HISTORY :

Date of last eye exam _____ Name of last eye doctor _____

Do you currently use glasses: N / Y If yes, how old is your present pair of glasses _____

Do you currently use contacts: N / Y If yes, what type: _____Brand name __soft __toric __Monovision/Multifocals __Rigid __Colored Cleaning solution used: _____

Do you sleep in your contacts: N / Y If yes, how often:_____

Replacement schedule: __Daily __2weeks __Monthly __Longer than 1 month

Do you have the following conditions:

Glaucoma	Yes	No	Thyroid Problems	Yes	No
Cataracts	Yes	No	Respiratory Problems	Yes	No
Macular Degeneration	Yes	No	Kidney Problems	Yes	No
Retinal Detachment	Yes	No	Arthritis	Yes	No
Lazy/Crossed Eye	Yes	No	Neurological Problems	Yes	No
Dry Eyes	Yes	No	Heart Problems	Yes	No
Flashes/Floaters	Yes	No	Seasonal Allergies	Yes	No
High Blood Pressure	Yes	No	Cancer	Yes	No
Diabetes	Yes	No	Alcohol Use	Yes	No
High Cholesterol	Yes	No	Nicotine Use	Yes	No

Are you in good health overall: YES / NO Are you pregnant: YES / NO

Medications: (incl. OTC) Condition: Name of Primary Care Physician: _____

_____ _____ Date of Last Physical exam: _____

_____ _____

_____ _____ Drug Allergies: __Y __N if so, which ones? ___

_____ _____ _____

_____ _____ Any eye drops you are using: _____

Does anyone in your Family (indicate whom) have the following conditions:

Glaucoma _____ Diabetes _____

Macular Degeneration _____ Cancer _____

Cataracts _____ Other: _____

A DILATED RETINAL EXAM enables us to provide a more thorough ocular health analysis. With the dilated pupils, we get a better view inside the eyes that allows us to detect early signs and changes of ocular pathology. A dilated retinal exam is extremely essential for diabetes, hypertension, high myopes, and/or any history of other related ocular diseases. The side effects are blurred near vision and light sensitivity. In some individuals, the distance vision may also be blurred.

As a convenience, we also offer retinal photography, which can be done without dilating the eyes. The photos are a good substitute for dilation as there are no side effects or blurred vision. In addition, there will be a photographic record for future comparison to see if any retinal changes have occurred.

WE ARE COMMITTED TO EARLY DETECTION AND PREVENTION OF EYE DISEASES. WE STRONGLY RECOMMEND THAT ALL OF OUR PATIENTS UNDERGO A THOROUGH RETINAL EXAM AS PART OF THEIR COMPREHENSIVE VISUAL ANALYSIS. There is an additional $25.00 fee for a dilated retinal exam and $10.00 for retinal photos. Please check the appropriate space below stating your preference:

_____ I DO WANT THE DILATED RETINAL EXAM

_____ I DO WANT THE non-dilated RETINAL PHOTOS

_____ I do NOT want photos or dilation performed

I understand that without these tests, certain eye disease and conditions may not be discovered. I agree to assume all risk associated with refusing these tests, indemnify, hold harmless, and release Eyedoc Vision Services, its employees, and optometrists, from any and all claims or liability whatsoever related to failure to diagnose and/or treat any eye condition due to lack of diagnosis and information which could have been obtained by these tests.

Signature _____ Date _____