EYEDENTITY eye CARE
Vision Source!

WELCOME to our office!
Practice of Optometry

* *If you are the parent or guardian of the patient, please fill out and sign this form on their behalf.*

PATIENT INFORMATION (PLEASE PRINT)

Name: Last _____ First _____ M.I. _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (_____)_____ Cell Phone: (_____)_____ ☐OK TO TEXT

SSN: ___ ___ ___-___ ___-___ ___ ___ ___ Date of Birth: _____/_____/_____ Age:_____ Sex: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic Partnership

Ethnicity: ☐ Caucasian ☐ African American ☐ Asian ☐ Pacific Islander ☐ Hispanic ☐ Other _____ ☐ Decline to Specify

Email Address: _____ ☐ OK TO E-MAIL

Employer: _____ Occupation: _____

Employer's Phone: (_____)_____ Extension: _____

In Case of an Emergency Contact:_____ Phone: (_____)_____

Relationship: _____

How did you find out about our office?:

☐ Insurance Website ☐ Local Advertisement ☐ Patient: _____ ☐ Other: _____

How would you like to be contacted for your yearly eye exam reminders?:

☐ Email ☐ Postcard ☐ Phone Call ☐ Other: _____

VISION INSURANCE (PLEASE PRINT)

Vision Insurance: _____

Primary Insured's Name: _____ Primary Insured's SSN: ___ ___ ___-___ ___-___ ___ ___ ___

Primary Insured's DOB: _____/_____/_____ Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Person Responsible for Payment (if same as above leave blank)

*Name: Last*_____*First*_____*M.I.*_____

*Address:*_____

*City:*_____*State:*_____*Zip Code:*_____

*Home Phone: (_____)*_____*Cell Phone: (_____)*_____

*SSN: ___ ___ ___-___ ___-___ ___ ___ ___ Date of Birth:*_____/_____/_____*Sex:* ☐ *Male* ☐ *Female*

Marital Status: ☐ *Single* ☐ *Married* ☐ *Divorced* ☐ *Widowed* ☐ *Domestic Partnership*

*Employer:*_____*Occupation:*_____

*Employer's Phone: (_____)*_____*Extension:*_____

PATIENT OCULAR HISTORY

Date of Last Eye Exam: _____ Name of Eye Doctor: _____

Name of Family Physician: _____ Date of Last Visit: _____

Do you wear glasses?	☐ **Yes**	☐ **No**	
Do you wear contacts?	☐ **Yes**	☐ **No**	
Are you interested in being fitted for contacts?	☐ **Yes**	☐ **No**	
Have you ever had eye surgery?	☐ **Yes**	☐ **No**	**If yes, when?** _____
Have you ever had an eye injury?	☐ **Yes**	☐ **No**	**If yes, when?** _____
Have you had Laser Vision Correction (LASIK)?	☐ **Yes**	☐ **No**	**If yes, when?** _____
Are you interested in discussing Laser Vision Correction?	☐ **Yes**	☐ **No**	

PATIENT MEDICAL HISTORY (PLEASE CIRCLE)

Cardiovascular Disease	**Yes**	**No**		Skin Conditions	**Yes**	**No**		Excessive Tearing	**Yes**	**No**
Asthma	**Yes**	**No**		Diabetes	**Yes**	**No**		Double Vision	**Yes**	**No**
Frequent Headaches	**Yes**	**No**		Arthritis	**Yes**	**No**		Cataracts	**Yes**	**No**
High Blood Pressure	**Yes**	**No**		Low Blood Pressure	**Yes**	**No**		Glaucoma	**Yes**	**No**
Thyroid Disease	**Yes**	**No**		HIV – AIDS	**Yes**	**No**		Macular Degeneration	**Yes**	**No**
Stroke	**Yes**	**No**		Hay Fever	**Yes**	**No**		Ocular Flashes	**Yes**	**No**
Hepatitis	**Yes**	**No**		Muscle Disease	**Yes**	**No**		Sensitivity to light	**Yes**	**No**
Neurological Disease	**Yes**	**No**		Dizziness	**Yes**	**No**		Itchy Eyes	**Yes**	**No**
Head Trauma	**Yes**	**No**		Cancer	**Yes**	**No**		Floaters	**Yes**	**No**
Sinus Problems	**Yes**	**No**		Depression	**Yes**	**No**		Are you pregnant?	**Yes**	**No**
Multiple Sclerosis	**Yes**	**No**		Shingles	**Yes**	**No**		Other Conditions?	**Yes**	**No**
Lupus	**Yes**	**No**		Current Smoker? How Long? How much do you smoke a day?						
Corneal Ulcers	**Yes**	**No**		Former Smoker? About how long ago did you stop smoking?						

Please list all medications that you are currently taking: _____

_____

_____

Please list all known allergies to medications: _____

Please list any medical or eye diseases that run in your family: _____

_____

Office Policy Regarding Contact Lenses:

1. *Except for cases of Doctor's Prescription change or manufacturer defect, disposable contact lens orders cannot be altered or cancelled after 24 hours of placing them.*
2. *The release of your contact lens prescription may not be possible on the day of your initial visit. Please discuss your request with the Doctor prior to your exam.*

Authorization

I certify that the given information on all pages of this form is correct to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I authorize the eye doctor to release any information including the diagnosis and the records of my treatment or examination rendered to me or my child to third party payers and/or health practitioners.

I authorize and request my insurance company to pay directly to the eye doctor. I understand that my vision insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. Any unpaid balances after (90) days accrue interest at the rate of 1.5% per month.

Signature:_____ Date:_____

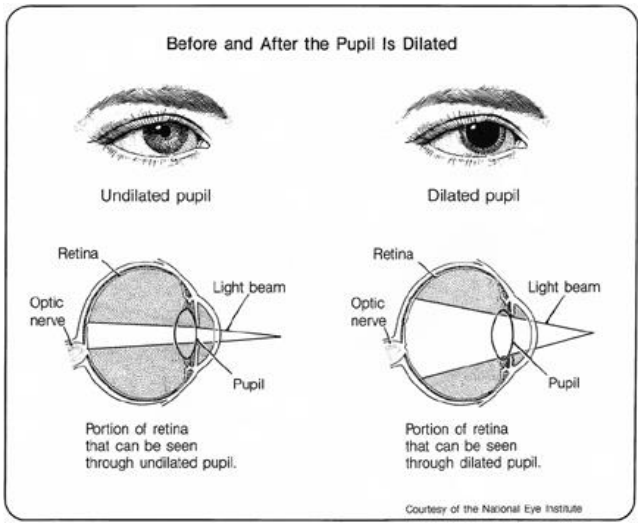
DILATION OF THE EYES

Routine dilation of the eyes or eye drop induced widening of the pupil or black portion of the eye is a recommended health check for not only your eye health, but your physical health as well. It is part of our complete eye exam and there is no additional charge. If you are concerned with, or have a family history of any of the following, you are strongly urged to have your eyes dilated today:

- Diabetes
- Cataracts
- High blood pressure
- Frequent headaches
- High nearsightedness
- Glaucoma or any other eye disease(s)
- Over the age of 40
- Sudden loss of vision
- Macular Degeneration
- Symptoms of flashes and/or floaters

Once your eyes have been dilated you may experience the following effects which may last 2 to 6 hours:

1. Increased sensitivity to light.
2. Mild blur of distance vision.
3. Inability to focus on near objects (e.g. reading will be difficult).



Due to the above effects, we recommend that you have someone drive you home. In most cases you can drive yourself. We also supply every dilated patient with disposable sunglasses. We request that you use caution when walking up or down stairs or curbs, and that you refrain from operating heavy equipment/machinery for at least 6 hours.

The doctor will be happy to answer any questions you may have.

Please check one:

_____ I wish to have my eyes dilated today.
_____ I do not wish to have my eyes dilated and assume the responsibility of having my eyes examined without dilation.
_____ I wish to have my dilation scheduled for another day. *(Please confirm with front desk)*

Patient Signature: _____ Date: _____

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ACKNOWLEDGMENT OF HIPAA & OFFICE POLICIES (Please see attached forms)

I acknowledge that I have reviewed a copy of Eyedentity Eye Care's Eyewear Warranty & Policies and Contact Lens Warranty & Fitting Policies.

I understand through this notice that my medical records will be retained in this office for a period of five years.

Patient Name: _____

Patient Signature: _____ **Date:** _____

PATIENT INFORMATION AND MEDICAL RECORD RELEASE AUTHORIZATION

Eyedentity Eye Care, LLC

PATIENT INFORMATION:

Last Name: _____First Name: _____M.I. _____

Date of Birth: _____/_____/_____ Sex: Male Female

Mailing Address: _____

City: _____ State: _____ Zip: _____

RELEASE OF INFORMATION:

Please tell us with whom we are allowed to discuss / disclose your personal health information.

Name: _____ Relationship: _____

Contact Information: _____

Name: _____ Relationship: _____

Contact Information: _____

Name: _____ Relationship: _____

Contact Information: _____

In compliance with *HIPAA regulations*, we are required to have confirmation that you have been offered a written copy of **Eyedentity Eye Care's** Notice of Privacy Practices, or an opportunity to review a copy of **Eyedentity Eye Care's** Notice of Privacy Practices.
If at any time you wish to change the information provided on this form, please ask for a new form prior to your appointment so your chart can be updated. Please do not hesitate to ask if you have any questions regarding the HIPPA regulations or **Eyedentity Eye Care's** Office Policies.
My signature below authorizes the release of medical information from **Eyedentity Eye Care** to the above named.

_____ ____/____/____

Patient/Responsible Party Signature Date