EYEDENTITY EYE CARE

VISION SOURCE

WELCOME to our office!
Practice of Optometry

*If you are the parent of 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

Email Address: _____ ☐ OK to E-Mail

SSN: ____/____ /_____ **Date of Birth:** ____/____/_____ **Age:** _____

Sex: ☐ Male ☐ Female **Gender:** _____ ☐ Decline to Specify

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

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

Employer: _____ **Occupation:** _____

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 ☐ Text ☐ No Reminder

VISION INSURANCE (PLEASE PRINT)

Vision Insurance: _____ **Member ID:** _____

Primary Insured's Name: _____

Primary Insured's SSN: _____/_____/_____ **Primary Insured's DOB:** ____/____/_____

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

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

Name: Last_____ First_____ M.I._____

Cell Phone: _____ Home Phone: _____

ACKNOWLEDGEMENT 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 OCULAR HISTORY

Name of Eye Doctor: _____ Date of Las Visit:

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

Do you wear ☐ Glasses ☐ Contact Lenses ☐ Neither ☐ Both

Are you interested in being fitted for contacts? ☐ Yes ☐ No

If yes, have you worn contact lenses before? ☐ Yes ☐ No

Are you interested in discussing laser vision correction? ☐ Yes ☐ No

Please list and date any previous eye injuries and/or surgeries, including laser vision correction (LASIK):

_____

PATIENT MEDICAL HISTORY

Diabetes	Yes	No	Skin Conditions	Yes	No	Excessive Tearing	Yes	No
High Cholesterol	Yes	No	Cardiovascular Disease	Yes	No	Double Vision	Yes	No
High Blood Pressure	Yes	No	Arthritis	Yes	No	Cataracts	Yes	No
Frequent Headaches	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	Asthma	Yes	No
Lupus	Yes	No	Corneal Ulcers	Yes	No	Other Conditions	Yes	No

If yes to any, please explain and date:

_____

Current Smoker: ☐ Yes ☐ No For how long? _____ How much per day? _____

Former Smoker: ☐ Yes ☐ No About how long ago did you quit? _____

Please list all medications that you are currently taking.

_____

_____

Please list all known allergies and reactions to medications.

_____

Please list any medical or eye diseases which run in your family.

_____

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.

Signature: _____ **Date:** _____

Office Policy Regarding Contact Lenses and Glasses:

- *Except for cases of Doctor's prescription change or manufacturer defect, disposable contact lenses and/or glasses orders cannot be altered or cancelled after being placed.*
- *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.*

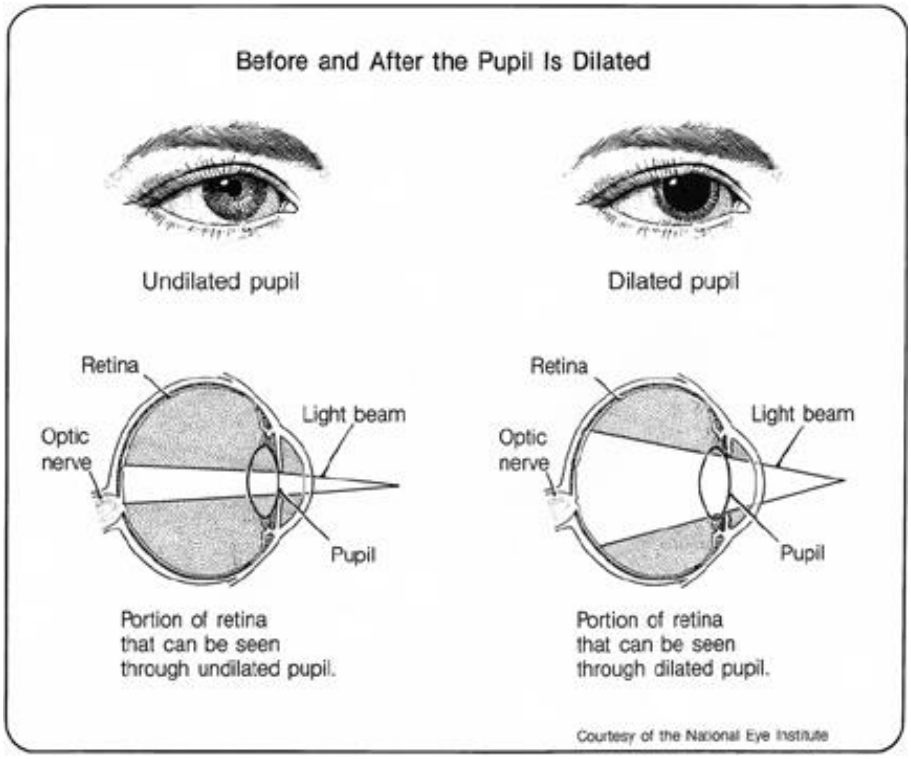
DILATION OF THE EYES

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
●Over the age of 40
●Symptoms of flashes and/or floaters
●High nearsightedness
●Glaucoma or any other eye disease(s)
●High Blood Pressure
●Sudden loss of vision
●Macular Degeneration
●Frequent Headaches

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.

Please check one:

☐ I wish to have my eyes dilated today

☐ I wish to have my dilation scheduled for another day. *(Please confirm with front desk)*

☐ I do not wish to have my eyes dilated and assume the responsibility of having my eyes examined without dilation.

Patient Signature: _____ Date: _____

PATIENT INFORMATION AND MEDICAL RECORD RELEASE AUTHORIZATION

Eyedentity Eye Care, LLC

PATIENT INFORMATION:

Name: Last_____ First_____ M.I._____

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

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:_____

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 HIPAA 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 Signature: _____ Date:_____