Advanced Eyecare & Vintage Eyewear

Welcome To Our Office

Today's Date ____/_____/____ Name_____

Street_____ City_____ State _TX____ Zip _____

Home Phone_____ Work Phone _____Birth Date____/_____/_____

SS #_____/_____/_____ Last Eye Exam____/____/____

Email address:_____ **May we friend you on Facebook? Yes☐ No☐**

Name of Medical Doctor _____ Dr.'s Phone _____

Any problems with your present contact lenses or glasses?_____

VERY IMPORTANT! Who may we thank for referring you to our office? Other…☐: _____

Building/Sign…….. ☐	Another Dr…….....☐	Insurance list…….. ☐
Web Page ……☐	Newspaper/Radio/TV…☐	Phone Book……... ☐

Name of friend or relative: _____

How will you settle your account today? ☐Care Credit (No interest 3, 6, 12 month Extended Payment Plan)

☐Check ☐Cash ☐Credit Card Flex spending account? No ☐Yes ☐

If medical care is provided all DEDUCTIBLES and COPAYS are DUE AT THE TIME OF SERVICE

PATIENT HISTORY (Do you currently have any problems with: (check box if answer is yes)

MEDICAL HISTORY	**Yes**		**Yes**		**Yes**
Allergic/Immunologic	☐	Endocrine (Thyroid)	☐	Muscles, Bones	☐
Anxiety	☐	Fever	☐	Pregnant/Nursing	☐
Cardiovascular	☐	Gastrointestinal	☐	Psychiatric	☐
Depression	☐	Genital, Bladder	☐	Respiratory	☐
Diabetes	☐	Headache	☐	Skin	☐
OCULAR HISTORY	**Yes**		**Yes**		**Yes**
Cataracts	☐	Eye infections	☐	Glaucoma	☐
Crossed eyes (lazy eye)	☐	Drooping eyelid	☐	Retinal disease	☐

Eye Injury's?:_____

SYSTEMIC SURGICAL HISTORY

List all surgeries and/or hospitalizations: _____

OCULAR SURGICAL HISTORY

List all ocular surgeries: _____

MEDICATIONS – SYSTEMIC/OCULAR

List any medications you currently take: _____

MEDICATION SIDE EFFECTS

Do you have any allergies to medications: _____

OCULAR COMPLAINTS	**Yes**		**Yes**		**Yes**
Blurred Vision(Aesthenopia)	☐	Dry/Sandy Feeling	☐	Eyelids Crusty	☐
Eye Fatigue/Soreness	☐	Redness	☐	Eyes Watery	☐
Pain/Pressure	☐	Burning	☐	Photo(Light) Sensitive	☐
Ocular Bleed/Hemorrhage	☐	Itching	☐	Discharge/Infection	☐
Foreign Body Sensation	☐	Eyelids Puffy/Droopy	☐	Squinting/Blinking	☐

Do you… (Check box if answer is yes)

☐ **Need prescription glasses?**
☐ **Bothered by glare or night vision?**
☐ **Work at a computer for extended periods?**
☐ **Do you ride a motorcycle?**
☐ **Interested in thinner, lighter lenses?**
☐ **Have trouble playing golf in your bifocals?**
☐ **Do your contacts get uncomfortable?**
☐ **Interested in contacts you don't have to clean?**
☐ **Interested in the latest in contacts?**
☐ **Interested in non-surgical Vision Correction?**
☐ **Want information on LASIK Correction?**
☐ **Have family members in need of eye care?**

CONTACT LENS WEARERS:

Contact Lens Material: Gas Permeable☐ Soft☐ Extended Wear☐ Are they Comfortable No☐ Yes☐

Contact Lens Brand _____ Contact Lens Powers: Right _____ Left Eye _____

Turn Over

OCULAR FAMILY HISTORY

DISEASE	Yes	Relationship
Blindness	☐	_____
Glaucoma	☐	_____
Macular Degeneration	☐	_____
Retinal Problems	☐	_____

SYSTEMIC FAMILY HISTORY

DISEASE	Yes	Relationship
Cancer	☐	_____
Diabetes	☐	_____
Heart Disease	☐	_____

SOCIAL HISTORY

Occupation(student)_____Employer(grade)_____ Marital Status:_____

Do you use tobacco? No☐ or Yes☐: type/amount _____

Do you use alchohol? No☐ or Yes☐: type/amount _____

Medicare, Primary Medical, and Vision Insurance

Insurance Signature on File

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me collect payment of my insurance and/or Medicare benefits, and I authorize payment of these benefits directly to **Advanced Eyecare & Vintage Eyewear** on my behalf for any services and materials furnished. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services. If I have other health insurance coverage (as indicated in Item 9 of the HCFA-1500 claim form or the electronically submitted claim), my signature authorizes release of the above medical information to the insurer or agency shown, and authorizes my doctor to act as my agent, as above.

_____

Signature

Retinal Images and Visual Field Screenings

"80% of all cases of blindness and serious sight loss could be prevented through proper eye care and treatment"
- The World Health Organization, The International Agency for the Prevention of Blindness

NON-ELECTIVE Procedure

Retinal Image Screening. Is a great new technology for detecting and monitoring eye diseases like glaucoma and macular degeneration. These high resolution images become a permanent part of your record and are ideal for managing retinal health and diseases. This does not take the place of dilation, but does expand the view of the retina when a patient chooses not to be dilated. The fee is included in our cash prices, but insurances **do not** cover the images. This procedure is performed on all patients. **If you prefer to be dilated** it is important that you inform our front desk personnel. Thank you. **The fee is $30**.

Initial_____

ELECTIVE Procedure

A computerized instrument enables us to provide an in depth **visual field** analysis. Visual field testing assists in identifying *undetected* disorders like glaucoma, retinal disease, and neurological disease (tumors, aneurysms, multiple sclerosis). The guideline for the visual field is all new patients age 18 years and older. (Every 3 years thereafter)

__Yes, I do want the visual field screening. ----------Fee is $19
__No, I do not want the visual field screening.

****Please note we are only able to treat one problem per visit. Multiple symptoms will likely require multiple visits****

_____ _____

Patient or Guardian Signature **Date** **Doctor's Signature** **Date**

By signing you are confirming:
(1) the authenticity of this history form (2) that we have offered you the chance to read/obtain a copy of our Privacy Act

Abilene Advanced Eyecare & Vintage Eyewear

Authorization of Release of Medical Information

Acknowledgement of Electronic Signature

By signing below, I am acknowledging acceptance of my electronic signature by device, means, or action as legally binding terms and conditions of all consents and agreements. I further agree that my electronic signature on all documents is valid as if I signed the document in writing.

Privacy regulations require us to have a release signed by our patients so we may speak with family members, friends, and other relations regarding your medical treatment and patient financial information. Each person you wish to be considered a contact must be listed individually by name (including spouse or significant other).

I hereby authorize **Abilene Advanced Eyecare & Vintage Eyewear** to release my medical information to the following:

Please Print:

1._____

Name Relationship to Patient

2._____

Name Relationship to Patient

3._____

Name Relationship to Patient

_____

Printed Name of Patient Patient's Date of Birth

_____

Patient's Signature Today's Date

_____

Guardian Signature Relationship to Patient Today's Date

This authorization will remain in effect until written notice from the patient is received cancelling the authorization of release.