

EYES IN SIGHT - WELCOME TO OUR OFFICE

 First Name Last Name M.I D.O.B Age SS # Occupation / Employer

 Home Address City / State / Zip Home Phone Mobile Phone Work Phone

 Insurance Plan Name / Group / Number Insured Person / SS # SELF SPOUSE CHILD
 Relationship

How were you referred to our office? _____

Reason for visit? Eye health exam Glasses update CL update Urgent eye care Other

Last eye exam date? Location? Given? Glasses CL No Rx needed

EYE HISTORY (circle all that apply)

Blur at distance	Y	N	
Blur at near	Y	N	
Strabismus / 'lazy eye'	Y	N	
Double vision	Y	N	
Flashes of light	Y	N	
Floaters	Y	N	
Dry eyes	Y	N	
Past eye infection	Y	N	when:
Past eye injury	Y	N	when:
Past eye surgery	Y	N	when:
Glaucoma	Y	N	FAMILY
Macular degeneration	Y	N	FAMILY
Cataract	Y	N	FAMILY
Retina problems	Y	N	FAMILY

HEALTH HISTORY (circle all that apply)

High blood pressure	Y	N	FAMILY
Diabetes	Y	N	FAMILY
Heart disease	Y	N	FAMILY
Thyroid	Y	N	FAMILY
Arthritis	Y	N	FAMILY
Lupus	Y	N	FAMILY
Asthma	Y	N	FAMILY
HIV/AIDS	Y	N	FAMILY
Headaches/migraines	Y	N	FAMILY
Cancer	Y	N	FAMILY
Pregnant	Y	N	
List Allergies:			
List Medications:			

VISUAL FIELD TEST: New technology and computerized testing tools have allowed eye-care doctors to evaluate the entire field of vision. Visual field testing allows us to check both central and peripheral vision. This is especially helpful in early detection of glaucoma, neurological disorders, and retinal defects. This may also help to rule out problems associated with chronic headaches. **The fee for this test is \$25.00.**
 YES: I wish to have this test performed NO: I do not wish to have this test performed today

DILATED FUNDUS EXAM (DFE): This is a standard procedure of a comprehensive eye exam. Dilation drops are used to relax the focusing muscles of the eye, and this allows a more thorough assessment of the back of the eye. The pupils remain dilated for an average of 3-5 hours. There is no additional fee for this test.
 YES: I wish to have this test performed NO: I do not wish to have this test performed today

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICE:

I acknowledge that I have read / reviewed a copy of the Eyes In Sight Notice of Privacy Practice.

Patient's Signature Below (parent or guardian if patient is under 18 years old):

Date Below:
