EYES IN SIGHT - WECOME TO OUR OFFICE

First Name _____ Last Name _____ M.I. _____ DOB _____ Age _____

Home Address _____ City/ Zip _____ Home Ph # _____ Mobile Ph # _____

Email:_____ Occupation:_____

_____ **O**SELF **O**SPOUSE **O**CHILD

Insurance Plan Name/ Group/ Number Insured Person/ SSN Relationship

How were you referred to our office? **O** Ins. **O** Family/Friend: if so, who_____
O Internet **O** Est. Patient **O** Other, please be specific_____

Reason for visit? **O** Eye health exam **O** Glasses update **O** CL update **O** Other_____

Last eye exam date? _____ Given? **O** Glasses **O** CL **O** No Rx needed

EYE HISTORY (mark all that apply)

Blur at:	Distance	Near	Both
Strabismus/ 'lazy eye'	Y	N	
Dry eyes	Y	N	
Eye Allergies	Y	N	
Floaters	Y	N	
Flashes of light	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
Retina problems	Y	N	FAMILY

List Allergies:

HEALTH HISTORY (mark all that apply)

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

List Medications:

VISUAL FIELD TEST: New technology & computerized testing tools have allowed eyecare 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, & retinal defects**. This may also help to rule out **problems associated with chronic headaches**. **The fee for this test is $25.00 and may be covered by your medical insurance**. Please provide us your medical insurance card so we can make a copy and verify.

YES: I wish to have this test performed **NO: I do not wish to have this test performed**

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 & this allows a more thorough assessment of the back of the eye and eye health. The pupils remain dilated for an average of 3-5 hours. Some common side effects include light sensitivity & blur at near. **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 but will return on** _____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICE:

I acknowledge that I have read/ reviewed a copy of the Eyes In Sight Notice of Privacy Practice and understand my information will not be released without my permission.

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

_____ _____