PATIENT INFORMATION

Last Name _____ First _____ Date_____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Age _____ Email address _____

Phone Numbers: Home _____ Work _____ Cell _____

Parent's Name (if under 18)_____ Spouse's Name (if married) _____

Occupation or Grade (if student) _____ Employer _____

How did you hear about us? _____ School (if student) _____

Approximate date of last exam _____ Previous Eye Doctor _____

Are you presently wearing glasses? _____ If not, have you ever worn glasses?_____

Are you currently wearing contacts? _____ Do you sleep in contacts?_____ If so, how long?_____

Type of contacts worn? ___ Soft Lenses ___ Daily Wear ___ Disposable
___ Hard or Gas Permeable ___ Extended Wear ___ Frequent Replacement

What are your reasons for visiting our office today? (Check all appropriate items)

___ General check-up
___ Lost or broken glasses
___ Want new glasses
___ Blurred distance vision
___ without glasses
___ with current glasses
___ Blurred near vision
___ without glasses
___ with current glasses
___ See spots or floaters
___ See flashing lights
___ Temporary vision loss

___ Eyes water
___ Eyes burn
___ Eyes red
___ Eyes feel dry
___ Eyes itch
___ Eyes mattering
___ Headaches
___ Eyestrain
___ Pain in eyes
___ Double vision
___ Light sensitive
___ Glare

___ Problems with current contact lenses
___ Want a new type of contacts
___ Soft Contacts or ___ Hard or Gas Perm Contacts
___ Daily Wear or ___ Extended Wear
___ Disposable or ___ Frequent Replacement
___ Want an updated prescription for the exact same type of contacts currently being worn.
___ Other (please list) :

_____

_____

Your general and ocular health (past or present). Check all that apply.

___ High blood pressure	___ Diabetes	___ Blindness	___ Cataracts
___ Heart problems	___ Allergies	___ Glaucoma	___ Eye turn
___ Respiratory problems	___ Asthma	___ Lazy eye	___ Poor color vision
___ Multiple sclerosis	___ Migraine headaches	___ Retinal disorder	___ Currently pregnant
___ Thyroid condition	___ Arthritis	___ Cancer	___ HIV positive

List any other visual and/or health conditions not listed above _____

_____

List any eye injuries, diseases, or surgeries you have had _____

_____

Has any family member had any of the above conditions? Please list relative and condition. _____

_____

List medications you are currently taking _____

Do you have any allergies to medications? _____

List any insurance or health care plan you have which will pay toward your eyecare _____

Method of payment: ___ Cash ___ Check ___ MC/Visa ___ American Express ___ Discover Other _____

Signature_____

OPTOMAP AND DILATION

Eclectic Eyewear strives to offer the best possible standard of care for our patients, which is why we offer state-of-the-art digital scanning technology to image the inside of your eye – The Optomap.

We recommend that all patients of all ages have a thorough retinal examination every year to detect and diagnose eye diseases. The Optomap is the preferred method over dilation. This non-invasive procedure allows a much broader and more detailed view of the retina and replaces the need for dilation in many cases. **Diseases such as macular degeneration, glaucoma, retinal detachments, diabetic retinopathy, tumors and other vision threatening conditions can be missed without a comprehensive examination of the retina.**

There is an additional fee of only $39 for the Optomap procedure, which covers both eyes, and this service is generally not covered by vision insurance.

<u>Advantages of the Optomap Exam over Dilation:</u>

- No blurred vision for a period of several hours
- No light sensitivity
- Image capture takes less than one minute
- See your own retina in the most comprehensive way
- Images are saved to your chart as a baseline for future exams

I have been informed of the importance of having a comprehensive retinal eye examination annually in the detection and diagnosis of eye disease and vision threatening conditions. I understand that I can have my retinas examined by either the Optomap procedure or by having my eyes dilated.

Please check one of the following:

___ I elect to have the Optomap procedure done at the additional fee of only $39.

___ I elect to have my eyes dilated. I understand that I will be blurry at near and sensitive to light for 4-6 hours after.

___ I would like to discuss further with the doctor before deciding.

Name (Please print): _____

Signature: _____ Date: _____

VISUAL FIELD SCREENING

Many major causes of blindness can often be detected by changes in a person's visual field. This highly sophisticated computerized instrument, known as frequency doubling technology, checks for areas of reduced vision in the central (straight-ahead) and peripheral (side vision) areas. Visual field testing is important in the early diagnosis of glaucoma, retinal problems, and some neurological diseases such as brain tumors and optic nerve disease. Unfortunately, an individual does not notice most visual field defects until very late stages. Early detection significantly increases the chances of either curing the disorder or at least minimizing its effects. If the visual field screening is contraindicated in your case the doctor will let you know.

There is an additional fee of $10.00 for the visual field screening and most insurances do not cover the cost.

Please check one of the following:

___ I elect to have the visual field screening done at the additional fee of $10.

___ I decline to have the visual field screening done.

___ I would like to discuss further with the doctor before deciding.

Name (Please print): _____

Signature: _____ Date: _____