WELCOME TO OUR OFFICE

NAME: ______________________________ DATE: ______________

ADDRESS: ______________________ CITY / STATE / ZIP: ______________

DAY PHONE: ______________________ EVENING / CELL PHONE: ______________

BIRTH DATE: ______________________ SOCIAL SECURITY #: ______________

HEALTH INSURANCE: ______________________ PRIMARY INSURED: ______________

RELATIONSHIP TO INSURED: MEMBER SPOUSE CHILD PRIMARY INSURED BIRTH DATE: ______________

PRIMARY INSURED ADDRESS: ______________________ CITY / STATE / ZIP: ______________

PRIMARY INSURED SOCIAL SECURITY: ______________________ LAST EYE EXAM: ______________

HOW WERE YOU REFERRED TO US? ______________________ PREVIOUS PATIENT? YES NO

EMAIL: ______________________ EMPLOYER: ______________

DILATION PROCEDURE: Dilation includes the use of topical medications to dilate the pupil of the eye, to detect disease such as glaucoma, retinal detachments, malignant growths, diabetic retinopathy, hypertensive retinopathy, etc… Having your pupils dilated is a painless procedure with some minor side-effects. These include: mild burning on installation of drops, sensitivity to light, inability to focus at near, and blurry distance vision for some patients. These side effects usually last no longer that 4 to 5 hours. Some patients find it difficult to drive, and thus must bring a driver with them. State law requires that all certified Optometrists must perform a dilated exam on:

- All new patients to our practice.
- All established patients who have previously not been dilated.
- All established patients who were previously dilated but deemed medically necessary to be again.

Dr. Fowler will do a dilated eye exam. If you find it inconvenient to have your eyes dilated at this visit, or wish not to have your eyes dilated, please indicate.
I understand the importance of having my eyes dilated and understand the possible side effects.
At this time **(PLEASE INITIAL):**

________ YES, I agree to allow dilation.

________ I would prefer to NOT have a dilated eye exam.

________ I would prefer to RE-SCHEDULE the dilation procedure. * There will be a $30.00 charge for this visit.

ASSIGNMENT, RELEASE, AND OFFICE POLICY: I hereby authorize the physician to release any information required to process a health insurance claim. I also authorize my insurance benefits to be paid directly to the physician and I understand that I am financially responsible for all non-covered services. I authorize health insurance plans to be billed for medical exams. I understand that all fees and charges are final. This includes contact lens fitting fees. Refunds/exchanges will not be issued. Therefore, payment delay, dispute, and withholding will not occur. I will be responsible to pay any attorney, collection, and related fees should collection occur.

PATIENT SIGNATURE: ______________________ DATE: ______________

NOTICE OF PRIVACY POLICY (HIPAA): I have received a copy of the Notice of Privacy Practices and I have read this consent and understand it. I understand that I have the right to restrict the use and disclosure of my health information. By signing below I consent to the use or disclosure of my health information for treatment, payment, and to conduct health care operations involving this office or related health care facilities.

PATIENT SIGNATURE: ______________________ DATE: ______________

Reorder 3/15 OBS 1-800-634-1876

Please check each item *Yes* or *No* as they relate to your health.

	Yes	*No*		*Yes*	*No*		*Yes*	*No*
EYES			**ENDOCRINE**			**NERVOUS SYSTEM / BRAIN**		
Double Vision			Diabetes - Type I or Type II			Seizures / Epilepsy		
Pain			***How long?:***			Numbness		
Floaters or Spots			Thyroid			Stroke - ***When:***		
Seeing Flashes of Light						Alzheimer's		
Dry Eyes			**CANCER**					
Decreased Vision			Location:			**PSYCHIATRIC**		
Sandy/Gritty Feeling			Radiation ☐ Chemotherapy ☐			Anxiety / Depression		
Excessive Tearing						Mood Swings / Difficult Sleep		
			GENERAL HEALTH					
BLOOD / LYMPH			Weight Loss			**KIDNEY / BLADDER / URINARY**		
Anemia			Fatigue			Prostate		
Easy Bruising			Fever			Urination Difficulty		
Prolonged Bleeding						Bladder		
Use Blood Thinners?			**STOMACH/ INTESTINES**			Kidney-Dialysis		
			Stomach Problems			Dialysis - ***# of times: wk***		
MUSCULOSKELETAL			Liver Problems					
Arthritis						**EAR, NOSE, MOUTH, THROAT**		
			CARDIOVASCULAR			Hearing - Loss / Problems		
ALLERGIC / IMMUNOLOGIC			Murmur			Mouth (dentures)		
Hay Fever			Chest Pain / Angina			Sinus		
			Palpitations					
LUNGS / RESPIRATORY			Heart Attack -			**SKIN**		
Cough			***When:***			Skin Rashes		
Wheezing			High Blood Pressure			Ulcers		
Emphysema			Hand or Ankle Swelling			Swelling		
Asthma								

PAST MEDICAL / SURGICAL HISTORY:

List your other illnesses not listed above	List your past Surgeries	Date

☐ Married ☐ Widowed ☐ Single ☐ Divorced Number of Children:__________

☐ Non-Smoker ☐ Smoker - # of packs per day?__________ ☐ No Alcohol ☐ Alcohol - Number of drinks per day?_________

Family/Social History: Check Self of No as related to your family history. Explain positive responses ie: Mother, Father, Sister, Brother, Grandparents

	Self	*No*	*Family Member*		*Self*	*No*	*Family Member*
Glaucoma				Diabetes			
Cataract				Hypertension			
Retinal				Vascular			
Macular Degeneration				Cancer			

Drug Allergies:______________________________ Other Allergies:______________________________

Medication Name:

______________________ **Rx OTC**

______________________ **Rx OTC**

______________________ **Rx OTC**

______________________ **Rx OTC**

______________________ **Rx OTC**

Medication Name:

______________________ **Rx OTC**

______________________ **Rx OTC**

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