M-EYE VISION

PATIENT INFORMATION Welcome to our office! **PLEASE PRINT** **TODAY'S DATE: _____/_____/_____**

LAST NAME: _____ **FIRST NAME**: _____ MI: _____ BIRTH: _____/_____/_____

□ **Male** State ID/ □ Single □Married

□ **Female** Driver's License #: _____ **Social Security #**: _____-_____-_____ □ Divorced □ Widow

Address: _____ Apt#: _____ City: _____ State: _____ Zip: _____

Email: Student/ School/

(PRINT)_____ Occupation: _____ Employer:_____

Home: (_____)_____-_____ Cell: (_____)_____-_____ Work: (_____)_____-_____ Other: (_____)_____-_____

Referred by: □ Family □ Friend or relative □ Zocdoc □ Google □ Newspaper □ Coupon □ Walk-in □ Magazine Ad □ School Ad

If personally referred, whom may we thank for the referral: _____

Ethnicity/Race: □ American Indian/Alaska Native □ Asian □ Black/African American □ Hispanic/Latino □ White/Caucasian □ other

INSURANCE INFORMATION

Major Medical Insurance Name: _____ Plan Name: _____

Medical Insurance ID #: _____ Group #: _____

Patient's Relationship to primary insurance card holder: □ Self □ Spouse □ Child □ Other: _____

Vision Insurance Name *(if applicable):* _____ ID #: _____

Patient's Relationship to primary insurance card holder: □ Self □ Spouse □ Child □ Other: _____

Please fill out section below if patient is not the primary card holder.

RESPONSIBLE PARTY: (If different than the patient, please complete the following)

(Circle) Mr./Mrs./Ms./Miss/Dr. Last Name:_____ First Name:_____ MI:_____

Date of Birth:_____ Gender: □ Male □ Female Social Security#:_____

Address:_____Apt#_____City_____State_____Zip_____

Cell Phone:_____ Home Phone:_____ Work Phone:_____

Email Address:_____ Employer: _____

For patients with insurance: in order to process your insurance claim, ***you must present your insurance card or voucher at the time of service***. Failure to do so may result in denial of your claim. Please understand that you are financially responsible for all charges, whether or not paid by said insurance. **By signing here you are stating that the primary insurance holder is AWARE of the use of his/her policy.**

Patient/Parent/Guardian Signature: _____ **Date**:_____

ACKNOWLEDGEMENT OF FINANCIAL DISCLAIMER AND POLICY

I acknowledge that I have received and/or read a copy of M-eye Vision's Financial Disclaimer and Policy.

Patient/Parent/Guardian Signature: _____ **Date**:_____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES (NPP)

I acknowledge that I have received and/or read a copy of M-eye Vision's notice of Privacy Practices.

Patient/Parent/Guardian Signature: _____ **Date**:_____

Computerized Visual Field Screening Testing:

Computerized visual field screening testing can help in the early detection of glaucoma, retinal problems, and some neurological diseases and enables us to better diagnose possible cause of headaches. We recommend that patients receive this procedure annually to ensure the most extensive comprehensive examination available. If your insurance does not cover the visual fields screening, the additional fee is $20.00.
Do you want computerized visual field screening testing today? **□ Yes □ No**

Patient Initial:_____ Date:_____

Optomaping:

Our office is proud to provide our patients with the most highly advanced digital retinal imaging technology available today! Our ability to view your internal retinal health is now dramatically improved with the Optomap. Your doctor is concerned about retinal problems such as macular degeneration, Glaucoma, retinal holes, retinal detachments, and diabetic retinopathy (All of which can lead to partial loss of vision or blindness). **EARLY DETECTION IS CRUCIAL!**

The optomap provides:

- Replacement of Pupil Dilation (Pupil Enlargement) for many patients.
- A digital computerized map of the retina.
- A view of the retinal layers where disease can start.
- The ability to show you your images today during your exam.
- A permanent record for your medical files (year to year screening for potential eye disease, and tracking of diagnosed eye disease).

If your insurance does not cover the Optomap, the additional fee for Optomap is $39.

□ Yes , I want this new technology with photos.
□ No, I decline this technology.

Patient Initial:_____ Date:_____

**** Bundle service and save! Computerized Visual Field Screening Test + Optomap for $49.00****
(if your insurance does not cover)

Pupil Dilation: (Pupil Enlargement)

Pupil dilation enlarges the size of the pupil temporarily by using an eye drop which allows the doctor a more thorough examination of your retina. Pupil dilation is sometimes used for determining an accurate glasses prescription for younger children. For most individuals, it will blur your near vision for approximately 4 hours. Dilation is covered by the insurance. For selfpay patients, there is an additional $20 fee for dilation.

Would you like to be dilated today? **□ Yes □ No If NO, please SIGN here:_____**

The doctors at M-eye Vision highly recommend a retinal exam yearly to check the internal health of the eye.

PLEASE READ AND SIGN. TURN OVER TO CONTINUE

PATIENT & FAMILY MEDICAL HISTORY (Please fill out all sections as accurate as possible)

List any medications that you take *(including birth control, aspirin, over the counter medications, and/or home remedies):*

□ None ___ _____ How often? _____

Do you have any allergies to medications? □ No □ Yes If yes, what? _____ Reactions: _____

Have you ever had: □ crossed/lazy eye □ drooping eyelid □ prominent eye □ glaucoma □ retinal disease □ cataracts □eye infection □ eye injury □ None If yes, When?

_____

List all major injuries, surgeries, hospitalizations you have had including dates: □ None

_____

_____

_

Primary Care Physician: _____ Last Visit: _____/_____/_____ Reason:_____

Last Optometrist/Ophthalmologist Visit: _____/_____/_____ Doctor's Name: _____ Phone #: (_____)_____-_____

Please √ any FAMILY/SELF diagnosed history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

Disease/Condition	*Patient/ Relative*	*Disease/Condition*	*Patient/Relative*	*Disease/Condition*	*Patient/Relative*
Blindness	□ _____	Macular Degeneration	□ _____	Diabetes	□ _____
Crossed/Lazy Eye	□ _____	Cancer	□ _____	Heart Disease	□ _____
Cataract	□ _____	Retinal Detachment	□ _____	High Blood Pressure	□ _____
Glaucoma	□ _____	Retinal Disease	□ _____	Stroke	□ _____
Lupus/autoimmune	□ _____	Arthritis	□ _____	Other: _____	□ _____

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

SOCIAL HISTORY

Do you wear glasses? □ No □ No, but interested. □ Yes If yes, Do you wear □ Readers □ Distance Only □ Multi-Focal □ Computer

Do you wear contacts? □ No □ No, but interested. □ Yes If yes, What kind? _____

Are you having any specific issues with your current glasses/contacts? □ No □ Yes → What? _____

Do you drive? □ No □ Yes If yes, do you have difficulty when driving? □ No □ Yes → Explain: _____

Do you use tobacco products? □ No □ Yes → What type: _____ Amount: _____ How long? _____

Do you drink alcohol? □ No □ Yes → What type: _____ Amount: _____ How long? _____

Do you use illegal drugs? □ No □ Yes → What type: _____ Amount: _____ How long? _____

Have you ever been exposed to or infected with: □ Gonorrhea □ Hepatitis □ HIV □ Syphilis □ None

Are you pregnant/breastfeeding □ Yes □ No Weeks of pregnancy: _____ Gave birth on: _____

Have you had a tetanus shot recently? □ Yes □ No If yes, When? _____ Reason: _____

To better assess your lifestyle and to optimize your vision, please check which applies to you.

□ Reading Books	□ Computer	□ Gardening	□ Sew/Needlepoint	□ Shooting
□ Music	□ Team Sports	□ Golfing	□ Skiing	□ Racquet Sports
□ Fishing	□ Hunting	□ Swimming	□ Water Sports	□ Wood working

□ Other_____ If none apply: □

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REVIEW OF SYSTEMS

Do ***you*** currently, or ***have you ever*** had any problems in the following areas (***mark all that apply***):

EYES	GENERAL	MUSCLES/BONES/JOINTS	BLOOD/LYMPH/OTHER GLANDS
☐ Eye pain/Soreness	☐ Fever	☐ Rheumatoid Arthritis	☐ Anemia
☐ Fatigue/Tired Eyes	☐ Weight Loss	☐ Joint Pains	☐ Cholesterol
☐ Foreign Body Sensation	☐ Weight Gain	☐ Muscle Pain	☐ Bleeding Problems
☐ Dryness	☐ Fatigue	☐ Head or Neck Injury	
☐ Sandy/Gritty Feeling		**SKIN**	**ALLERGIC/IMMUNOLOGIC**
☐ Redness	**EAR, NOSE, & THROAT**	☐ Growths	☐ Seasonal Allergies
☐ Burning	☐ Allergies/Hay Fever	☐ Rashes	☐ Rheumatoid
☐ Itching	☐ Sinus Congestion	☐ Acne	☐ AIDS
☐ Excess Tearing/Watering	☐ Dry Mouth/Throat	☐ Metal Allergies	☐ Allergy Shots
☐ Mucous Discharge	☐ Hearing Loss		☐ Lupus
☐ Chronic Infection of Eye/Lid	☐ Rosacea	**NEUROLOGICAL**	**GASTROINTESTINAL**
☐ Squinting	☐ Runny Nose	☐ Headaches	☐ Diarrhea
☐ Glare/Light Sensitivity	☐ Post-Nasal Drip	☐ Migraines	☐ Constipation
☐ Distorted Vision/Halos	☐ Chronic Cough	☐ Seizures	☐ Ulcer
☐ Double Vision	**VASCULAR/CARDIOVASCULAR**	☐ Alzheimer's	☐ Reflux
☐ Loss of vision	☐ Diabetes	☐ Parkinson's	☐ Intestinal Problems
☐ Loss of Side Vision	☐ High Blood Pressure		☐ Liver Problems
☐ Blurred Vision	☐ Heart Pain	**PSYCHIATRIC**	If any options are marked above or you have a condition not listed, Please explain: _____
☐ Flashes	☐ Heart Surgery	☐ Depression	
☐ Floaters	☐ Vascular Disease	☐ Anxiety	
☐ Sties	☐ Stroke	☐ Insomnia	
☐ Chalazae	☐ Congestive Heart Failure		
RESPIRATORY	**GENITAL/KIDNEY/BLADDER**	**ENDOCRINE**	
☐ Asthma	☐ Kidney Stones	☐ Thyroid	
☐ Bronchitis	☐ Frequent Urination	☐ Diabetes (Type I/ Type II)	
☐ Emphysema	☐ Impotence		
☐ COPD			

OTHER FAMILY MEMBERS, STILL LIVING AT HOME

Spouse: _____ DOB _____ Child 1: _____DOB _____

Child 2: _____ DOB _____ Other: _____ DOB _____

IN CASE OF AN EMERGENCY:

Name of local friend or relative (not living at the same address): _____

Relationship: Contact #: ( ) -

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize M-Eye Vision or Insurance Company to release any information required to process my claims.

Patient/Guardian Signature _____ Date _____/_____/_____

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