PATIENT INFORMATION

FIRST NAME: | MIDDLE NAME: | LAST NAME: | SEX: ☐ MALE ☐ FEMALE

ADDRESS: | DATE OF BIRTH: | AGE:

CITY: | STATE: | ZIP: | EMAIL (FOR YEARLY REMINDERS):

HOME PHONE | CELL PHONE: | WORK PHONE: | YEARS SINCE LAST EXAM:

OCCUPATION: | EMPLOYER: | REASON FOR TODAY'S VISIT:

MEDICAL HISTORY

CHIEF MEDICAL COMPLAINT: ☐ POOR DISTANCE VISION ☐ POOR NEAR VISION ☐ BOTH

☐ OTHER _____

Interested in Contacts? ☐ Yes ☐ No | Do you currently wear glasses? ☐ Yes ☐ No

Problems with your contacts? ☐ Yes ☐ No | Interested in LASIK surgery? ☐ Yes ☐ No

REVIEW OF MEDICAL SYMPTOMS- *(PLEASECIRCLE YES OR NO TO ANY CONDITIONS THAT APPLY TO YOU)*

Y	N	WEIGHT LOSS, FEVER, HEADACHES	Y	N	MACULAR DEGENERATION
Y	N	HEARING LOSS, SINUS PROBLEMS	Y	N	DISTORTED/DOUBLE VISION
Y	N	CHEST PAINS, IRREGULAR HEARTBEAT, HEART CONDITION	Y	N	LAZY EYE(S)
Y	N	SHORTNESS OF BREATH, WHEEZING, ASHTMA	Y	N	WATERY/ITCHY EYES
Y	N	HEARTBURN, DIARRHEA, ACID REFLUX	Y	N	EYE PAIN OR SORENESS
Y	N	PARALYSIS, NUMBNESS	Y	N	FLOATERS/SPOTS IN VISION
Y	N	ECZEMA, SKIN PROBLEMS	Y	N	FLUCTUATING VISUAL ACUITY
Y	N	DEPRESSION, ANXIETY, MENTAL ILLNESS	Y	N	RETINAL DETACHMENT, HOLE OR TEAR
Y	N	DIABETES	Y	N	LOSS OF VISION
Y	N	ELEVATED CHOLESTEROL LEVELS	Y	N	LOSS OF PERIPHERAL VISION
Y	N	THYROID PROBLEMS	Y	N	MUCUS/DISCHARGE FROM EYES
Y	N	ANY TYPE OF CANCER	Y	N	REDNESS/SWELLING/BURNING OF EYES
Y	N	ANEMIA, SICKLE CELL, EXCESSIVE BLEEDING	Y	N	PREVIOUS EYE SURGERY
Y	N	KINDEY/BLADDER PROBLEMS	Y	N	PREVIOUS EYE INJURY/INFECTION
Y	N	PREGNANT OR NURSING	Y	N	GLAUCOMA
Y	N	HIGH BLOOD PRESSURE	Y	N	CATARACTS

FAMILY MEDICAL HISTORY (*CHECK IF ANY FAMILY MEMBERS HAVE ANY*)

☐ GLAUCOMA ☐ BLINDNESS ☐ HEART CONDITION

☐ CATARACTS ☐ DIABETES ☐ OTHER: (*Please list*)

☐ MACULAR DEGENERATION ☐ HIGH BLOOD PRESSURE _____

MEDICATIONS AND ALLERGIES

LIST OF MEDICATIONS:

LIST OF ALLERGIES:

INSURANCE INFORMATION

PRIMARY VISION INSURANCE	PRIMARY MEDICAL INSURANCE
Insurance name:	Insurance name:
Primary member name	Primary member name
Primary member DOB:	Primary member DOB:
Insurance ID # or SSN:	Insurance ID # or SSN:

CONTINUED ON BACK ⇨

INSURANCE SIGNATURE ON FILE

I certify that the information given by me in applying for vision/medical insurance is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and I authorize payment of these benefits directly to the doctor on my behalf for any services furnished. I authorize any holder of medical information about me to release to the Health Care Financing Administration and it's agents any information needed to determine these benefits payable to related services.

I understand I am responsible for the balance of fees not paid by my insurance

Patient Signature (Patient's Legal Representative) _____ Date _____

HIPPA PRIVACY ACKNOWLEDGMENT OF RECEIPT OF NOTICE PRIVACY PRACTICES, ALL PATIENTS PLEASE SIGN

I, _____ (please print patient or patient's representative's full legal name) have been presented with the Notice of Privacy Policy of Master Eye Associates, and have been offered upon request a copy of such policy to keep for my records.

_____ (Please Initial) I hereby acknowledge that I have been provided with a copy of the policy

_____ (Please Initial) I hereby refuse to acknowledge receipt of the policy. I understand that even though I may refuse to sign this acknowledgement, the provider may still provide treatment to me

Patient's Signature or Patient's Legal Representative _____ Date _____

ADDITIONAL TESTING

At Master Eye Associates we pride ourselves on providing our patients with the best possible standard of care. We are committed to early detection and prevention of eye diseases. We strongly recommend that all of our patients receive all these tests as part of our comprehensive visual analysis once per year.

A DILATED FUNDUS EXAM enables us to provide a more thorough ocular health analysis. With the dilated pupils, we get a better view inside the eyes that allow us to detect early signs and changes of ocular pathologies. Dilation is recommended for diabetics, hypertensives, and/or any history of related ocular disease. The side effects are blurred near vision and sensitivity to light for 3-4 hours.

There is a $20 fee for dilation, however most major medical insurances may cover this procedure

☐ Yes, I want the dilation ☐ I would like to discuss it with the Doctor

AN OPTOMAP RETINAL SCAN provides the doctor with a view of approximately 82% of your retina in a single capture. The captured retinal image becomes a permanent part of your medical file, enabling the doctor to make important comparisons should potential vision threatening conditions show themselves at a future examinations. There are no side effects from an Optomap Retinal Scan

There is a $35 fee for the Optomap, however most major medical insurances may cover this procedure

☐ Yes, I want the Optomap Retinal Exam ☐ I would like to discuss it with the Doctor

A VISUAL FIELD ANALYZER is a computerized instrument that provides us a more thorough analysis of your field of vision. The Visual Field Screening can assist us in the detection of glaucoma, retinal problems, some neurological diseases and may diagnose most causes of headaches.

There is a $15 fee for the visual field screening, however most major medical insurances may cover this procedure

☐ Yes, I want the Visual Field Screening ☐ I would like to discuss it with the Doctor

OFFICE POLICIES

I understand that without these tests, eye disorders may not be discovered. I agree to assume all risk associated with refusing these tests, indemnify, hold harmless and release master eye associates, it's employees and optometrists from any and all claims or liability whatsoever related to failure to diagnose and/or treat any eye conditions due to lack of diagnostic information which could have been obtained by these tests. All visits to the office are due and payable at the time of service. Fees paid for any service are **NON REFUNDABLE**. There will be no fee for follow up visits for glasses or contact lenses fitting within 60 days of the initial exam. Any follow ups on glasses or contact lenses past 60 days will be subject to a $20 fee.

Patient Signature or Patient's Legal Representative _____ Date _____