



Patient Information

Today's Date: _____
 Last Name: _____
 First Name: _____ MI: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Home Phone: _____
 Gender: M F Date of Birth: _____
 Age: _____ Grade: _____
 Parent's Name: _____
 Contact Phone: _____
 Contact Email: _____
 Texting OK? Yes No

Vision Insurance:
 VSP EyeMed Other: _____
 Medical Insurance:
 BCBS Medicare Priority Health Aetna
 Cigna Cofinity Other _____

How did you find out about our office?

Referred:
 Who may we thank: _____
 Insurance Provider Locator
 Internet: Which website? _____
 Direct Mail
 Other: _____

Privacy Practices for Health Information

NOTICE OF PRIVACY PRACTICES: I have been offered a copy of Premier Eyecare's statement on privacy practices.

AUTHORIZATION TO RELEASE INFORMATION: I authorize Premier Eyecare to release any information including diagnosis, records of treatment, or examinations rendered to me or my child during the period of such eye care to 3rd party payers and/or health practitioners.

CONSENT FOR TREATMENT: I hereby grant my authorization and consent for medical treatment and procedures for myself and/or minor children as may be necessary for proper health care.

 Parent/Guardian Signature Date

CHILD FORM

Lifestyle Questions

Are you planning on purchasing glasses today?
 Yes No Maybe
Are you considering contact lenses for your child?
 Yes No Maybe
Why do you feel your child needs a visual evaluation?

How long has this problem/difficulty been observed?

Does your child...? (Check all the apply)

- ..wear prescription glasses?
- ..have ultraviolet protection sunwear?
- ..have "back up" prescription eyewear?
- ..wear contact lenses? Brand? _____
- ..interested in a non-surgical approach to vision correction (Ortho-K)?
- ..have a rapidly increasing prescription?

Dilation Consent/Retinal Photos Consent

Dr. Garretson and the American Optometric Association recommend a **dilated eye examination** to fully assess the health of your eyes. With dilation, drops are placed in the eyes to enlarge the pupils so that the doctor can carefully examine you for eye disease. Dilation will cause sensitivity to light and will make your near vision temporarily blurry.

___ Yes, I consent to have my child's eyes dilated today.
 ___ No, I do not wish to have my child's eyes dilated, and I agree to hold the practice harmless as a result.

Dr. Garretson also recommends **screening retinal photography** as an extension to your comprehensive eye health and vision exam. This instrument provides important diagnostic information and can be performed without the use of dilating drops. These photographs will become a permanent part of your electronic medical record in our office and form a baseline to track any subtle changes in your eye health from year to year. There is an additional fee of \$30 for retinal photography.

___ Yes, I would like my child to have retinal photos
 ___ No, I do not want my child to have retinal photos

 Parent/Guardian Signature

The information in this confidential case history is critical to the evaluation of your vision and health.

Patient Medical History	
Pediatrician: _____ Location: _____ Date of Last Physical: _____	
REVIEW OF SYSTEMS	
Have you ever been diagnosed for the following health problems?	
Constitution	Genitourinary
<input type="checkbox"/> Cancer	<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Fatigue Syndrome	<input type="checkbox"/> Prostate Cancer
ENT	Musculoskeletal
<input type="checkbox"/> Sinusitis	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Dry Mouth	<input type="checkbox"/> Ankylosing Spondylitis
Neuro	Integumentary (Skin)
<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Eczema
<input type="checkbox"/> Stroke/CVA	<input type="checkbox"/> Rosacea
<input type="checkbox"/> Migraine	Endocrine
Psych	<input type="checkbox"/> Type 2 Diabetes
<input type="checkbox"/> Depression	<input type="checkbox"/> Type 1 Diabetes
<input type="checkbox"/> Anxiety Disorder	<input type="checkbox"/> Thyroid Dysfunction
Cardiovasc	Hematologic/Lymphatic
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Anemia
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> High Cholesterol
Respiratory	Allergic/Immunologic
<input type="checkbox"/> Asthma	<input type="checkbox"/> Allergies
<input type="checkbox"/> COPD	<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/> Sleep Apnea	<input type="checkbox"/> Lupus
Gastrointestinal	
<input type="checkbox"/> Crohn's	
<input type="checkbox"/> Ulcer	
<input type="checkbox"/> Acid Reflux	
CURRENT MEDICATIONS (Rx or Over the Counter)	
(List name of medications including eye drops & vitamins)	

Allergies to medications? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If so, what medications? _____	

Have you had any surgeries? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If so, please describe: _____	

Premature birth? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Any complications during pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Birth weight: _____ APGAR score: _____	
Shown normal development? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Patient Eye History	
Date of Last Eye Exam: _____	
Previous Eye Doctor: _____	
EYE CONDITIONS	
Have you been diagnosed with any of the following?	
Cataract	<input type="checkbox"/>
Macular Degeneration	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>
Diabetic Retinopathy	<input type="checkbox"/>
Dry Eye	<input type="checkbox"/>
Retinal Detachment	<input type="checkbox"/>
Amblyopia (Lazy Eye)	<input type="checkbox"/>
Strabismus (Eye Turn)	<input type="checkbox"/>
Are you currently experiencing any of the following problems?	
EYE CONCERNS	
Redness	<input type="checkbox"/>
Burning	<input type="checkbox"/>
Itching	<input type="checkbox"/>
Tearing	<input type="checkbox"/>
Discharge	<input type="checkbox"/>
VISION CONCERNS	
Blurry Vision <u>without</u> glasses/CLs	<input type="checkbox"/>
Blurry Vision <u>with</u> glasses/CLs	<input type="checkbox"/>
Eyestrain	<input type="checkbox"/>
Eye Pain	<input type="checkbox"/>
Severe light sensitivity	<input type="checkbox"/>
Headache	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>
Loss of Vision	<input type="checkbox"/>
Flashes/Floaters	<input type="checkbox"/>
Family Medical/Eye History (Check all that apply)	
Please note any family history (parents, grandparents, siblings, children) for the following conditions:	
	Which family member?
Cancer <input type="checkbox"/>	_____
Type 1 Diabetes <input type="checkbox"/>	_____
Type 2 Diabetes <input type="checkbox"/>	_____
Hypertension <input type="checkbox"/>	_____
Glaucoma <input type="checkbox"/>	_____
Cataract <input type="checkbox"/>	_____
Macular Degeneration <input type="checkbox"/>	_____
Glaucoma <input type="checkbox"/>	_____
Retinal Problems <input type="checkbox"/>	_____