PREMIER EYECARE

Patient Information

Today's Date: ______________________________
Last Name: ______________________________
First Name: ______________________ MI: _____
Address: ______________________________
City: _____________ State: _____ Zip: _______
Home Phone: ______________________________
Cell Phone: ______________________________
Gender: M F Date of Birth: _______Age:______
Patient SSN: ______________________________
Marital Status: ______________________________
Employer: ______________________________
Occupation: ______________________________
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 Eycare 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.

______________________________ ______________
Patient Signature Date

Lifestyle Questions

Are you planning on purchasing glasses today?
❑ Yes ❑ No ❑ Maybe
Are you planning on getting a contact lens evaluation today? (Additional fees apply.)
❑ Yes ❑ No ❑ Maybe

Do you…? (check all that apply)

❑..have ultraviolet protection sunwear?

❑..wear contact lenses? What kind? ________________

❑..work at a computer? __________ hrs/day

❑..interested in a non-surgical approach to vision correction (Ortho-K)?

❑..want information on LASIK surgery?

❑.. have children?

What are your hobbies?

____

What specific problems do you have with your vision, eyes, glasses, or contact lenses?

____

Dilation Consent/iWellness Consent

iWellness Retina Scan

- NEW technology – A quick, non-invasive scan of your eye similar to an MRI or ultrasound.
- The scan shows the health of the deeper layers of the retina, which cannot be seen with regular equipment, allowing us earlier detection of problems that may affect your vision.
- This test is recommended for all new patients and then every 2-3 years afterwards, depending on risk factors. This test can usually be done without the use of dilating drops.
- There is an additional fee of $35 for the iWellness Retina Scan.

___ Yes, I would like to have the iWellness Retina Scan
___ No, I do not wish to have the iWellness Retina Scan

Pupillary Dilation

- Drops are placed in the eyes to enlarge the pupils so that the doctor can carefully examine your eyes for disease.
- Dilation will cause sensitivity to light and will make your near vision blurry for approximately 3-6 hours.

___ Yes, I consent to have my eyes dilated
___ No, I do not wish to have my eyes dilated

____
Patient Signature

★PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED★

Patient Medical History

Primary Physician: ______________________
Location: ______________________
Date of Last Physical: ______________________

REVIEW OF SYSTEMS
Have you ever been diagnosed for the following health problems?

Constitution
❑ Cancer
❑ Fatigue Syndrome

ENT
❑ Sinusitis
❑ Dry Mouth

Neuro
❑ Multiple Sclerosis
❑ Stroke/CVA
❑ Migraine

Psychiatric
❑ Depression
❑ Anxiety Disorder

Cardiovasc
❑ Hypertension
❑ Heart Disesase

Respiratory
❑ Asthma
❑ COPD
❑ Sleep Apnea

Gastrointestinal
❑ Crohn's
❑ Ulcer
❑ Acid Reflux

Genitourinary
❑ Kidney Disease
❑ Prostate Cancer

Musculoskeletal
❑ Arthritis
❑ Ankylosing Spondylitis

Integumentary (Skin)
❑ Eczema
❑ Rosacea

Endocrine
❑ Type 2 Diabetes
❑ Type 1 Diabetes
❑ Thyroid Dysfunction

Hematologic/Lymphatic
❑ Anemia
❑ High Cholesterol

Allergic/Immunologic
❑ Allergies
❑ Rheumatoid Arthritis
❑ Lupus

CURRENT MEDICATIONS (Rx or Over the Counter)
(List name of medications including eye drops & vitamins)

____
____
____

Allergies to medications? ❑ Yes ❑ No
If so, what medications? ______________________
____

Have you had any surgeries? ❑ Yes ❑ No
If so, please describe: ______________________
____

Are you pregnant or nursing? ❑ Yes ❑ No

Do you use: ❑ Tobacco ❑ Alcohol ❑ Other substances

Patient Eye History

Date of Last Eye Exam: ______________________
Previous Eye Doctor: ______________________

EYE CONDITIONS
Have you been diagnosed with any of the following?

Cataract ❑
Macular Degeneration ❑
Glaucoma ❑
Diabetes ❑
Diabetic Retinopathy ❑
Dry Eye ❑
Retinal Detachment ❑
Amblyopia (Lazy Eye) ❑
Strabismus (Eye Turn) ❑

Are you currently experiencing any of the following problems?

EYE CONCERNS
Redness ❑
Burning ❑
Itching ❑
Tearing ❑
Discharge ❑

VISION CONCERNS
Blurry Vision without glasses/CLs ❑
Blurry Vision with glasses/CLs ❑
Eyestrain ❑
Eye Pain ❑
Severe light sensitivity ❑
Headache ❑
Double Vision ❑
Loss of Vision ❑
Flashes/Floaters ❑

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	❑	______
Type 1 Diabetes	❑	______
Type 2 Diabetes	❑	______
Hypertension	❑	______
Glaucoma	❑	______
Cataract	❑	______
Macular Degeneration	❑	______
Glaucoma	❑	______
Retinal Problems	❑	______