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

How did you find out about our office?

❑ Referred:

Who may we thank:_____

❑ Insurance Provider Locator
❑ Internet: Which website? _____
❑ 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.

_____ _____
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 brand? _____

❑..work at a computer? _____ hrs/day

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

What are your hobbies?

_____

Dilation Consent/iWellness Consent

iWellness Retina Scan

- 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.
- There is an **additional fee of $39** 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

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 Disease

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	❑	_____