

WELCOME TO PEARLAND EYE CARE

PATIENT INFORMATION

Thank you for choosing our practice for your eye-care needs.

Please complete this form (3 pages) in ink. If you have any questions or concerns, do not hesitate to ask. We will be happy to assist you in any way.

(PLEASE PRINT)

Date _____

Name _____
(Mr., Mrs., Ms., Dr.) First MI Last Nickname Social Security No.

Address _____ Apt. No. _____ City _____

State _____ Zip _____ Home Phone No. _____ Work Phone No. _____ Ext. _____

Date of Birth _____ Age _____ Sex _____ Occupation _____
(MM/DD/YYYY) (M/F)

Employer/School _____ Hobbies _____

Referred by: Family Friend Doctor Yellow Pages Ad Coupon Walk-in Recall Letter Newspaper Other _____

RESPONSIBLE PARTY

Name of Person Responsible for account _____

Relationship to Patient _____ Contact Phone No. _____

Address _____ Apt. No. _____ City _____

State _____ Zip _____ Employer _____ Work Phone No. _____ Ext. _____

Drivers License No _____ Method of Payment: Cash Check Visa MasterCard Discover

VISION INSURANCE INFORMATION

Name of Insurance Plan _____ Group Number _____

Name of Insured _____ Relationship to Patient _____

Date of Birth Of insured _____ Insured's Social Security or Member ID number _____

IMPORTANT HEALTH HISTORY

Reason for today's exam _____ Date of Last Exam _____

Name of last eye doctor _____

Please List all surgeries _____

Please list all drug allergies _____

Please List all medications you are currently taking _____

Please continue on next pg →

Review of Symptoms-Please check all that apply to you:

Eyes

- Blindness Y N
- Loss of vision Y N
- Distorted Vision Y N
- Blurred vision Y N
- Double Vision Y N
- Cataracts Y N
- Flashes or floaters Y N
- Dry Eyes Y N
- Watery Eyes Y N
- Red eyes Y N
- Mucus Discharge Y N
- Burning or itching Y N
- Sandy or gritty feeling Y N
- Eye pain or soreness Y N
- Glare/Light sensitivity Y N
- Chronic Eye infections Y N
- Crossed Eyes Y N
- Tired Eyes Y N
- Halos Y N
- Vision Therapy Y N
- Eye surgery Y N
- Retinal Detachment Y N
- Glaucoma Y N

Personal Medical History

- Allergies
 - Hay Fever Y N
 - Medicine Allergies Y N
- Cardiovascular
 - Heart Pain Y N
 - High Blood Pressure Y N
 - Vascular disease Y N
- Ears, Nose, Mouth, Throat
 - Sinus Problems Y N
 - Chronic cough Y N
 - Dry Throat/ Mouth Y N
 - Chronic Ear Infection Y N
- Endocrine
 - Thirsty all the time Y N
 - Frequent Urination Y N
 - Diabetes Y N
 - Thyroid Problems Y N
- Gastrointestinal
 - Diarrea Y N
 - Constipation Y N
 - Ulcers Y N
- Genitourinary
 - Genitals Y N
 - Kidneys Y N
 - Bladder Y N

Personal Medical History

- Hematological
 - Anemia Y N
 - Bleeding problems Y N
- Integument
 - Skin Y N
 - Breast Y N
- Musculoskeletal
 - Arthritis Y N
 - Rheumatoid Arthritis Y N
 - Muscle Pain Y N
- Neurological
 - Headaches Y N
 - Migraines Y N
 - Seizures Y N
- Psychiatric
 - Nervous Disorders Y N
 - Depression Y N
 - Compulsive Behavior Y N
- Respiratory
 - Asthma Y N
 - Shortness of Breath Y N
 - Emphysema Y N
 - Lung Cancer Y N
- Constitutional Symptoms
 - Fever Y N
 - Weight loss Y N

Does anyone in the family have a history of the following?

- Cataracts Thyroid Arthritis Blindness Turned or lazy eye High Blood Pressure Glaucoma Heart Condition Diabetes

Please check any of the following that apply to you:

- Frequent Headaches Allergies Pregnant Sinus Trouble Drug allergies Given birth in the last 6 months

Do you currently wear glasses? Y N Do you work at a computer or video display terminal? Y N If yes how many hours? _____

When do you wear your glasses?

- All the time Reading/Near work Work Safety distance task only Computer work
 Other (please explain) _____

Have you ever worn contacts? Y N Are you interested in wearing contact lenses? Y N

If so, what brand _____ or Unsure

- If so what style (check all that apply) Soft Gas Permeable (RGP) Bifocal Progressive Disposable
 Conventional Extended wear Toric Clear Color
 Unsure

PUPIL DILATION/FUNDUS PHOTO

Dilation of the pupil is now considered a standard procedure in a comprehensive eye examination. Dilating drops enlarge the size of the pupil (the center black spot of the eye) and allow the doctor a more thorough examination of the retina (back of the eye). Dilation assists in detection of glaucoma, cataracts, diabetic and hypertensive retinal change, retinal hole, tears, and detachment as well as some types of tumors. The side effects are light sensitivity and trouble focusing up close. Even though the side effect lasts about 3 to 5 hours, you should be able to drive home. However, you do have the option to have the fundus photo done which will have no side effects. The cost of the fundus photo is \$30.00.

- Pupil Dilation: Yes No Discuss with doctor
 Fundus Photo: Yes No Discuss with doctor

PERIMETER TEST (Visual Fields)

A perimeter test is performed to detect any form of visual (peripheral) field loss. Visual field abnormalities may occur due to disease or disorders of the eye, optic nerve, or brain. Some conditions may include glaucoma, diabetes, macular degeneration, retinal abnormalities, double vision, color vision abnormalities, and certain types of tumors. The cost of a Perimeter test is **\$30.00**.

Perimeter Test: Yes No Discuss with Doctor

Fundus Photo and Perimeter Package: \$50 Yes No
 (Save \$10)

Pearland Eye Care

ACKNOWLEDGMENT OF RECEIPT

I acknowledge that I have received a copy of Pearland Eye Care Notice of Privacy Practices.

Patient Name _____

Signature _____ Date _____

I acknowledge that I have been given the following options related to communicating with Pearland Eye Care, its

I agree to allow Pearland Eye Care doctors and staff to leave messages on my answering machine, answering service or with an individual at my home or workplace that identifies the message as originating from Pearland Eye Care. I understand that clinical information will not be part of this message.

Please circle one of the following:

Yes, I agree

No, I do not agree

I agree to allow Pearland Eye Care to send me marketing materials/ clinical information concerning services that may contain my name and that of Pearland Eye Care and/or an individual optometrist or ophthalmologist providing care at Pearland Eye Care.

Please circle one of the following:

Yes, I agree

No I do not agree

Assignment & Release/Services & Materials Rendered: I hereby authorize my insurance benefits to be paid directly to the physician and understand that I am financially responsible for non-covered services. I authorize the physician to release information required to process this claim. I also acknowledge that if I am not using insurance benefits, payment is expected in full at time of services and/or materials rendered.

Signature of responsible party: _____