Welcome to *Beyond 20/20 Eye Care.* Please take a moment to complete this profile to help us meet your eyecare needs.

## PATIENT INFORMATION

Name_____ Date of Birth _____ Age _____ Gender: M F

If Child, Parent's Name _____ Social Security # _____

Address_____ City _____ State _____ Zip _____

Phone Number (Home) _____ (Work) _____ (Cell) _____

Occupation _____ Employer _____ Email Address _____

Whom may we thank for referring you to our office? _____

Emergency Contact Person and Number _____

## MEDICAL & VISION INSURANCE INFORMATION

Medical Insurance Company _____ Member I.D. # _____

Vision Insurance Company _____ Member I.D. # _____

Name of Primary Policy Holder _____ Birthdate _____ Gender: M F

Social Security # _____ Employer _____ Relationship to Patient: Self Spouse Parent

## PATIENT OCULAR HISTORY

When was your last eye exam? _____ What was the doctor's name? _____

Do you currently wear? ___Prescription Glasses, Which type? __Single Vision __Bifocal __Readers __Progressive

___Contact Lenses, Brand Name _____ Solution Name_____

Average Wearing Time _____ Replacement Schedule_____

Please check any Special Eye Wear Interests? ___ Prescription Sunglasses ___Sports Glasses ___Computer Glasses

Please check any of the following conditions that apply:

| | | | | |
|---|---|---|---|---|
| __Blurred Distance Vision | __Watery Eyes | __Floaters | __ Eye Surgery | __Retinal Disorder |
| __Blurred Near Vision | __Dry Eyes | __Halos Around Light | __Eye Infection | __Macular Degeneration |
| __Eye Strain | __Itchy, Burning Eyes | __Flashes of Light | __Eye Injury | __Glaucoma |
| __Light Sensitive | __Red Eyes | __Eye Injury | __Cataracts | __Other _____ |

## MEDICAL HISTORY

Date of last medical (physical) exam? _____ Doctor's Name_____ Office # _____

Please check if you have had any of the following medical conditions:

| | | | | |
|---|---|---|---|---|
| __High Blood Pressure | __Thyroid Disease | __High Cholesterol | __Tuberculosis | __Headaches/Migraines |
| __Diabetes | __Arthritis | __Hepatitis | __Asthma | __Pregnant ___ Months |
| __Heart Disease | __Cancer | __Multiple Sclerosis | __Allergies | __Other _____ |

Please list all medications you are currently using, **including** over the counter medications:

_____ _____ _____

_____ _____ _____

Please list any allergies: _____ _____

Please list any previous surgeries: _____ _____

Please check if you have any of the following conditions and list the treatment for that condition:

- General: Weight loss or gain, Fever _____
- Ears/Nose/Throat/Mouth: Hearing Loss, Sinus Problems _____
- Respiratory: Short of breath, Wheezing, Asthma, Cough _____
- Heart: Chest Pain, Irregular Heartbeat _____
- Digestive: Heartburn, Diarrhea, Reflux _____
- Neurologic: Paralysis, Numbness _____
- Skin: Rashes, Eczema _____
- Psychiatric: Depression, Anxiety, Mental Illness _____
- Endocrine: Diabetes, Thyroid _____
- Cancer: Any Type _____
- Blood: Anemia, Sickle Cell, Excessive Bleeding _____
- Urinary: Kidney, Bladder Condition _____
- Other; Please list _____

## SOCIAL HISTORY

Do you drink alcohol? __Yes __No
Do you smoke? __Yes __No
Do you have a history of drug abuse? __Yes __No
Do you drive? __Yes __No

## FAMILY HEALTH HISTORY

Please check the medical condition(s) that applies to any of your family members:

| | | | | |
|---|---|---|---|---|
| __Glaucoma | __Amblyopia, Lazy Eye | __High Blood Pressure | __High Cholesterol | __Multiple Sclerosis |
| __Macular Degeneration | __Blindness | __Diabetes | __Thyroid Disease | __Lupus |
| __Cataracts | __Retinal Disease | __Heart Disease | __Cancer | __Other _____ |

## DILATED EXAMINATION

A dilated exam allows a more thorough view of the retina and can detect many conditions within the eye that may not be detected during a routine eye exam. This exam is highly recommended for patients with a history of glaucoma, cataracts, diabetes, myopia, headaches, and any other conditions that may affect the integrity of the retina. Your near vision will be impaired for approximately 4-6 hours. You will also be light sensitive until your pupils constrict to its normal size. **This procedure is included in the comprehensive exam.**

__ Yes, I agree to have the dilated exam.

__ No, I decline to have the dilated exam performed. I am aware of the risks associated with the failure to detect any eye conditions due to the lack of information that could have been obtained by this procedure.

## NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. If you have any questions about this Notice of Privacy Practices, you may ask a member of the Beyond 20/20 staff. We will strive to continue to maintain the privacy of your protected health information.

I hereby acknowledge that I have been presented a copy of the NOTICE OF PRIVACY. _____
Signature

## THANK YOU FOR FILLING THIS FORM COMPLETELY!

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my (or my child's) ocular and medical status.

I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents. I authorize Beyond 20/20 Eye Care to release information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____
Signature of Patient (Or Parent/Guardian of a Minor) Please Print Your Name Date