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

PATIENT INFORMATION

Name_____Date of Birth _____Age ____

Gender: M F

If Child, Parent's Name _____Last 4 of Social Security # _____

Address_____City _____State ____Zip _____

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

Occupation _____Employer _____Email Address _____

Who may we thank for referring you to our office?

_____

Emergency Contact Person and Phone

_____

Primary Insurance Holder _____DOB _____

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 __Progressive (no line) __Readers

Do you currently wear contact lenses? _____ Brand Name _____ Solution Name _____

Average contact lens wearing time per day _____

Replacement Schedule _____

Please check any special eye wear interests:

___ Prescription Sunglasses ___Sports Glasses ___Computer Glasses

Please circle any of the following conditions that apply:

Blurred Distance Vision Watery Eyes Floaters Eye Surgery Retinal Disorder Blurred Near Vision

Dry Eyes Halos around Lights Eye Infection Macular Degeneration

Eye Strain Itchy, Burning Eyes Flashes of Light Eye Injury Glaucoma

Light Sensitivity Red Eyes Cataracts Other _____

MEDICAL HISTORY

When was your last physical (medical) exam? _____ Doctor's Name and phone_____

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

__Heart Disease __High Blood Pressure __High Cholesterol __Diabetes __Thyroid Disease

__Cancer __Arthritis __Asthma __Allergies/Sinusitis __Hepatitis __Multiple Sclerosis

__Tuberculosis __Headaches/Migraines __Pregnant ___Months __Other_____

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

_____

_____

Please list any allergies:

_____

Please list any previous surgeries:

_____

REVIEW OF SYSTEMS

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

□ General: Weight Loss or gain, Fever

_____

□ Ears/Nose/Throat/Mouth: Hearing Loss, Sinus Problems

_____

□ Respiratory: Shortness of Breath, Wheezing, Asthma, Cough

_____

□ Heart: Chest Pain, Irregular Heartbeat

_____

□ Endocrine: Diabetes, Thyroid

_____

□ Neurologic: Paralysis, Numbness

_____

□ Skin: Rash, Eczema

_____

□ Psychiatric: Depression, Anxiety, Mental Illness

_____

□ Digestive: Heartburn, Diarrhea, Reflux

_____

□ Cancer: Any Type

_____

□ Blood: Anemia, Sickle Cell, Excessive Bleeding

_____

□ Urinary: Kidney, Bladder Condition

_____

□ Muscles/Bones/Joints

_____

□ Allergic/Immunologic

_____

□ 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 conditions that apply to any of your family members:

__Glaucoma __Macular Degeneration __Cataracts __Amblyopia __Corneal Disease
__Retinal Disease __Multiple Sclerosis __Diabetes __High Blood Pressure __Heart Disease
__Thyroid Disease __Cancer __Other _____

DILATED EXAM

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 normal size. **This procedure is included in the cost of 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 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 strive 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 OUT THIS FORM COMPLETELY

I understand that the information 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 dependent's. I authorize Beyond 20/20 Eyecare 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 Minor) Please Print Your Name Date