Advanced Eyecare & Vintage Eyewear

Welcome To Our Office

Todays Date ____/_____/____ Name_______________________________
Street_______________________________________ City__________________ State _TX____ Zip _________
Home Phone______________________ Work Phone ____________________Birth Date____/_____/_____
SS #______/_______/________ Last Eye Exam____/____/____ Email______________________________
May we contact you? Yes☐ No☐
Name of Medical Doctor ___________________________ Dr.'s Phone ________________________________
Any problems with your present contact lenses or glasses?____
VERY IMPORTANT! Who may we thank for referring you to our office? Name of friend or relative: _____________________ Other?: ☐Building/Sign ☐Another Dr. ☐Insurance list ☐Web Page ☐Newspaper/Radio/TV ☐Directory: Yellow Pages/Area Wide/Name Numbers ☐Other:__________________

How will you settle your account today? ☐ Care Credit (No interest 3, 6, 12 month Extended Payment Plan) ☐Check ☐Cash ☐Credit Card Do you participate in a flex spending account? No ☐Yes ☐

If medical care is provided all DEDUCTIBLES and COPAYS are DUE AT THE TIME OF SERVICE

Review of Systems **Do you currently have any problems with: (Check box if answer is yes)**

GENERAL	Yes		Yes		Yes
Headache	☐	Respiratory	☐	Psychiatric	☐
Fever	☐	Gastrointestinal	☐	(anxiety, depression)	☐
Ears, Nose, Throat	☐	Genital, Bladder	☐	Endocrine	☐
(sinus, ear infection, cough…)	☐	Muscles, Bones	☐	(DIABETES, Thyroid)	☐
Cardiovascular	☐	Skin	☐	Allegic/Immunolgic	☐

EYES	Yes		Yes		Yes
Tired Eyes	☐	Blurred Vision	☐	Loss of Side Vision	☐
Double Vision	☐	Eye Soreness/Pain	☐	Dryness	☐
Mucous Discharge	☐	Redness	☐	Sandy/Gritty Feeling	☐
Itching	☐	Burning	☐	Foreign Body Sensation	☐
Loss of Vision	☐	Excess Tearing	☐	Glare/Light Sensitivity	☐

Do you… (Check box if answer is yes)

☐Have trouble watching TV in your bifocals?
☐Think you might benefit from thinner, lighter lenses?
☐Interested in a "Test Drive" with the latest in contacts?
☐ Are you bothered by glare?
☐Spend long periods outdoors?
☐Have prescription sunglasses?
☐Work at a computer for extended periods?
☐Have prescription glasses?
☐Prefer not to wear your glasses at times?
☐Want information on Laser Vision Correction?
☐Interested in non-surgical Vision Correction?
☐Have more than 1 pair of current RX glasses?
☐Have children?
☐Have family members in need of eyecare?
☐Have trouble playing golf in your bifocals?
☐ Do you ride a motorcycle?

Past Medical History

Do you have any allergies to medications? If yes, explain: ____

List any medications you currently take:____

List all surgeries and/or hospitalizations:____
Have you ever been diagnosed with: ☐crossed eyes ☐lazy eye ☐drooping eyelid ☐glaucoma ☐retinal disease ☐cataracts ☐eye infections ☐eye injury:____
Are you pregnant and/or nursing? No ☐ Yes ☐
Do you wear contact lenses? No ☐ Yes ☐ If yes, how old is your current pair? _________________________
Type of contact lenses: Gas Permeable ☐ Soft ☐ Extended Wear ☐ Are they Comfortable No ☐ Yes ☐

Contact Lens Brand _________________ Contact Lens Powers: Right _______________ Left Eye _____________

Turn Over

Family Medical History

DISEASE	Yes	Relationship	DISEASE	Yes	Relationship
Blindness	☐	____________	Diabetes	☐	____________
Glaucoma	☐	____________	Heart Disease	☐	____________
Retinal Problems	☐	____________	Cancer	☐	____________
Macular Degeneration	☐	____________	Thyroid	☐	____________

Social History

Occupation (or Grade) _________________________ Employer (or School) _______________________________

Marital Status:___________________ Do you use tobacco? No or Yes: type/amount_________________________

Medicare, Primary Medical, and Vision Insurance

Insurance Signature on File

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me collect payment of my insurance and/or Medicare benefits, and I authorize payment of these benefits directly to **Gabriel Avila, OD** on my behalf for any services and materials furnished. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services. If I have other health insurance coverage (as indicated in Item 9 of the HCFA-1500 claim form or the electronically submitted claim), my signature authorizes release of the above medical information to the insurer or agency shown, and authorizes my doctor to act as my agent, as above.

____
Signature

Retinal Images and Visual Field Screenings

"80% of all cases of blindness and serious sight loss could be prevented through proper eye care and treatment"
- The World Health Organization, The International Agency for the Prevention of Blindness, 2005

1. Alternative to Dilation – Retinal Image Screening. Dilation of the pupils is necessary to check the internal health of the eyes. Our new technology, the Nidek AFC 12 Megapixel Camera, lets us look at the inside of the eyes without having to dilate. No more blurred vision causing you to miss work or school, sunlight sensitivity or need for a driver to take you home.*****
The fee for this is included in our cash prices, but insurances do not cover the images. **The fee is $10**.

2. A computerized instrument enables us to provide an in depth **visual field** analysis. Visual field testing assist in identifying *undetected* disorders like glaucoma, retinal disease, and neurological disease (tumors, aneurysms, multiple sclerosis). The guideline for the visual field is all new patients age 18 years and older. (Every 3 years thereafter)

__Yes, I do want the visual field screening. ------------------------Fee is $19
__No, I do not want the visual field screening.

____
Guardian's Printed Name

______________________________________ ______________________________________
Patient or Guardian Signature **Date** **Doctor's Signature** **Date**

By signing you are confirming:
(1) the authenticity of this history form (2) that we have offered you the chance to read/obtain a copy of our Privacy Act

***Certain symptoms and diseases require dilation. If that is the case we will be sure to inform you.**