Advanced Eyecare & Vintage Eyewear

Welcome Back To Our Office

Today's Date ____/_____/____ Name________________________________ Date of Birth_____/____/______

If your address, phone number, or email has changed please fill in the area below, otherwise SKIP

Street_____________________________________ City__________________ State _TX____ Zip _________

Home Phone_____________________ Work Phone ___________________

Email address:___________________________________ **May we friend you on Facebook? Yes☐ No☐**

Any problems with your present contact lenses or glasses?______________________________________

How will you settle your account today?

☐Care Credit (No interest Extended Payment Plan) ☐Check ☐Cash ☐Credit Card ☐Flex spending account

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

MEDICAL HISTORY:____

OCULAR HISTORY:____

MEDICATIONS:____

OCULAR COMPLAINTS	**Yes/No**		**Yes/No**		**Yes/No**
Blurred Vision (Aesthenopia)	☐ ☐	Dry/Sandy Feeling	☐ ☐	Eyelids Crusty	☐ ☐
Eye Fatigue/Soreness	☐ ☐	Redness	☐ ☐	Eyes Watery	☐ ☐
Pain/Pressure	☐ ☐	Burning	☐ ☐	Photo(Light) Sensitive	☐ ☐
Ocular Bleed/Hemorrhage	☐ ☐	Itching	☐ ☐	Discharge/Infection	☐ ☐
Foreign Body Sensation	☐ ☐	Eyelids Puffy/Droopy	☐ ☐	Squinting/Blinking	☐ ☐

Do you… (Check box if answer is yes)

☐ **Need prescription glasses?**
☐ **Bothered by glare or night vision?**
☐ **Work at a computer for extended periods?**
☐ **Do you ride a motorcycle?**
☐ **Interested in thinner, lighter lenses?**
☐ **Have trouble playing golf in your bifocals?**
☐ **Do your contacts get uncomfortable?**
☐ **Interested in contacts you don't have to clean?**
☐ **Interested in the latest in contacts?**
☐ **Interested in non-surgical Vision Correction?**
☐ **Want information on LASIK Correction?**
☐ **Have family members in need of eye care?**

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

NON-ELECTIVE Procedure

Retinal Image Screening - Is a great new technology for detecting and monitoring eye diseases like glaucoma and macular degeneration. The high-resolution images become a permanent part of your record and are ideal for managing retinal health and diseases. This does not take place of dilation, but does expand the view of the retina when a patient chooses not to be dilated. This procedure is performed on all patients. The fee for this **is included** in our cash prices, but insurances **do not** cover the images. **If you prefer to be dilated** it is important that you inform our front desk personnel. **The retinal image fee is $30.**

Initial______________________

ELECTIVE Procedure

A computerized instrument enables us to provide an in-depth **visual field** analysis. Visual field testing assists 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.

****Please note: In order to keep our schedule, patients with multiple symptoms may require multiple visits****

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.**

Abilene Advanced Eyecare & Vintage Eyewear

Authorization of Release of Medical Information

Acknowledgement of Electronic Signature

By signing below, I am acknowledging acceptance of my electronic signature by device, means, or action as legally binding terms and conditions of all consents and agreements. I further agree that my electronic signature on all documents is valid as if I signed the document in writing.

Privacy regulations require us to have a release signed by our patients so we may speak with family members, friends, and other relations regarding your medical treatment and patient financial information. Each person you wish to be considered a contact must be listed individually by name (including spouse or significant other).

I hereby authorize **Abilene Advanced Eyecare & Vintage Eyewear** to release my medical information to the following:

Please Print:

1.____

Name Relationship to Patient

2.____

Name Relationship to Patient

3.____

Name Relationship to Patient

____

Printed Name of Patient Patient's Date of Birth

____

Patient's Signature Today's Date

____

Guardian Signature Relationship to Patient Today's Date

This authorization will remain in effect until written notice from the patient is received cancelling the authorization of release.