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 $39**

**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 $25**

__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.