# PATIENT INFORMATION FORM

**Patient Information**

First Name _____ Street Address _____

Last Name _____ Suite/Apt. _____

Date of Birth _____ City _____

Gender [ ] Male [ ] Female State _____

Mobile Phone _____ Zip Code _____

Home Phone _____ Marital Status _____

Email _____ SS No. _____

Employer _____ Occupation _____

How may we contact you to confirm and remind you about annual appointments?

[ ] Email [ ] Home Phone [ ] Mobile Phone [ ] Mail [ ] None

# MEDICAL AND OCULAR HISTORY FORM

**Reason for visit (please check one):**

[ ] Annual exam for glasses age of years of current (sun)glasses:

_____

[ ] Annual exam for glasses & contacts [ ] First time wearer for contacts

Current contact lens brand: (i.e. Acuvue Oasys, Air Optix,, Biofinity, Frequency 55)

_____

[ ] Annual exam (patient does not wear glasses or contacts)

[ ] Other reason for visit: _____

Has the patient been to our location before? [ ] Yes [ ] No

**Please check one:**

[ ] Patient has become aware of changes in his/her: [ ] close-up vision [ ] distance vision [ ] both

[ ] Patient is experiencing no difference in his/her vision.

**Last exam date:** _____ [ ] Unknown

Is the patient taking any medication(s) (prescription or over the counter)? [ ] None If yes, please list

_____

_____

Is the patient allergic to any medications or have any known allergies? [ ] None If yes, please list

_____

_____

**Do you drink?**: [ ] Yes [ ] No [ ] Social **Do you smoke?**: [ ] Yes [ ] No [ ] Social

**Eye Surgery History**: [ ] None [ ] Right Eye [ ] Left Eye [ ] Both eyes

[ ] If Yes, Date of surgery: _____ Reason for surgery: _____

**Family Medical/Ocular History Check all that apply. Leave blank if none.**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| cancer | [ ] mother | [ ] father | [ ] brother | [ ] sister | [ ] son | [ ] daughter | [ ] self |
| diabetes | [ ] mother | [ ] father | [ ] brother | [ ] sister | [ ] son | [ ] daughter | [ ] self |
| high blood pressure | [ ] mother | [ ] father | [ ] brother | [ ] sister | [ ] son | [ ] daughter | [ ] self |
| cataracts | [ ] mother | [ ] father | [ ] brother | [ ] sister | [ ] son | [ ] daughter | [ ] self |
| macular degeneration | [ ] mother | [ ] father | [ ] brother | [ ] sister | [ ] son | [ ] daughter | [ ] self |
| glaucoma | [ ] mother | [ ] father | [ ] brother | [ ] sister | [ ] son | [ ] daughter | [ ] self |
| retinal detachment | [ ] mother | [ ] father | [ ] brother | [ ] sister | [ ] son | [ ] daughter | [ ] self |

**Additional Comments:**

## PATIENT PRIVACY CONSENT

I have reviewed the HIPAA Notice of Privacy Practices and have been given the right to secure a copy of this form. I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1998 (HIPAA) and detailed in the Notice of Privacy Practices.

_____

Patient/Responsible Party Signature Date

## FINANCIAL POLICY AND CONSENT

I certify that the given personal and insurance information is correct to the best of my knowledge. I authorize and request my insurance company to pay directly to TruVision Eye Care LLC. I understand that my vision and/or medical insurance carrier my pay less than the actual bill for services. I agree to be responsible for the full payment of all non-covered services rendered on my behalf or my dependents. ALL NON-COVERED SERVICES WILL BE DISCLOSED IN ADVANCE BEFORE RENDERED. TruVision Eye Care only accepts VISA, MASTERCARD, DISCOVER, AND CASH as forms of payment; personal checks are not accepted. In the event it becomes necessary to collect fees through litigation, the patient agrees to pay all collection fees, court costs, deposition fees, and reasonable attorney fees incurred.

_____

Patient/Responsible Party Signature Date

## IMPORTANT INFORMATION CONCERNING YOUR EYE HEALTH

Imaging the retina OR dilation with eye drops allows the doctor a much better view inside the eye to detect problems as glaucoma, cataracts, retinal tears, macular degeneration, diabetes and high blood pressure. Without retinal exam, the doctor has a limited view of the interior of the eye and would not be able to detect any pathology that may occur in the far periphery of the eye.

It is strongly recommended that patients receive either the retinal photos **OR** the dilation evaluation. It is especially important for those patients who have a history of diabetes, high blood pressure, headaches, flashes of light or floaters, high nearsightedness, cataracts or family history of glaucoma or retinal issues.

**PLEASE ONLY SELECT ONE**

☐ I WOULD LIKE TO HAVE THE RETINAL PHOTOS DONE

☐ I WOULD LIKE TO HAVE THE DILATION DONE

☐ I DO NOT WISH TO HAVE THE DILATION OR RETINAL PHOTOS

_____

Patient/Responsible Party Signature Date