PATIENT INFORMATION

Vision Source Family Eye Care Lebanon

Name: _____ Date: _____
(Last) (First) (Middle Initial)

Sex: ☐ Male ☐ Female **Date of Birth:** _____ SSN: _____ Single ☐ Married ☐ Other ☐

Home Phone#: _____ Cell Phone#: _____ E-Mail: _____

Mailing Address: _____
(Street) (City) (State) (Zip Code)

Employer: _____ Employer Phone#: _____

Primary Care Physician: _____ Pharmacy: _____

Emergency Contact Person *Outside Patient's Home*: _____ Phone#: _____

NOTICE OF PRIVACY PRACTICES & Consent to Be Treated Agreement

A "Notice of Privacy Practices" that describes how my protected health information is used and disclosed, has been made available to me to read, I have read or it has been explained to me. I understand I may request a printed copy at any time. I understand by signing this form below I am giving consent to be examined and treated.

I authorize Vision Source Family Eyecare to discuss and disclose the health care or billing information to others as provided below:

Name: _____ Relationship: _____ Phone ☐ Email ☐ Both ☐

FINANCIAL RESPONSIBILITY-by signing you agree you have read and agree to the following policies:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I also authorize Vision Source Family Eyecare or my insurance company to release any information required to process my claims. I understand that all benefits quoted to me are not a guarantee of payment from my insurance company, and that final determination can only be made when the claim is processed. I understand that I am financially responsible for any balances due. I agree I may incur expenses for not attending scheduled appointments, without 24 hrs. notification, up to the amount of $100.00. I agree to a $25.00 insufficient funds fee, if my check is returned and agree payment will need to be in cash. I acknowledge I agree to Family Eyecare's Warranty/Return/Refund policy for materials and I also understand no refund will be given for physician services.

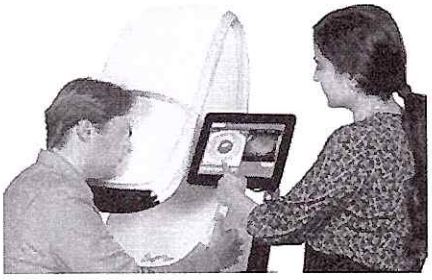
_____ Date: _____

Signature of Patient **OR** (Responsible Party, if patient is a minor)

The optomap (computer image of the retina)-No dilation required

*Dr. Montgomery wants **ALL** patients to have a digital image of the retina annually. It can now be done **without dilation** for most patients.*

- **No** light sensitivity, blurry vision, or trouble focusing on close objects, after the test.
- *Produces a computer image the physician will show you in the exam room.*
- *Can detect: Retinal problems such as macular degeneration, glaucoma, retinal holes, retinal detachments and diabetic retinopathy, as well as other health problems such as diabetes and high blood pressure.*
- *Allows the physician to compare images from year to year and to monitor changes in health. Early detection is crucial!*
- *The test is only $29.00 (usually not covered by insurance).*



Staff Only: Consent Y or N

*Interested in information about **contact lenses** today?*

***Yes**, I'd like to know more about the exam and fees associated with contact lenses.* *(Please check if interested)* ☐

No, I am not interested in information about contact lenses today.

(Please check if NOT interested) ☐

Name:_____ Date:_____

REASON FOR VISIT

What is the primary reason for your visit today? _____

What services are you interested in receiving today? (Check all that apply)

- ☐ General Eye Exam
- ☐ Glasses Exam
- ☐ Contact Lens Fitting
- ☐ Evaluation for Laser Vision Correction
- ☐ Treatment for Eye Infection, Injury, or other specific problem (specify) _____

Today, are you experiencing any of the following ocular or vision related symptoms?

- ☐ Blur at Distance
- ☐ Blur at Near
- ☐ Trouble with Computers
- ☐ Eye Pain
- ☐ Eye Redness
- ☐ Eye Itching
- ☐ Dry Eyes
- ☐ Tearing
- ☐ Headaches
- ☐ Double Vision
- ☐ Floaters
- ☐ Flashes
- ☐ Light Sensitivity
- ☐ Other (specify) _____
- ☐ **NONE OF THE ABOVE**

If so, please provide details (location, severity, duration, timing, context, etc.)_____

PATIENT OCULAR HISTORY

Date of last eye exam: _____/_____/_____ Previous Eye Doctor Name: _____

Were your eyes dilated? ☐ Yes ☐ No Do you wear: ☐ Glasses ☐ Contact Lenses

Please list any eye drops, eye ointments, or eye vitamins you use:

Have you had any of the following:

- ☐ Eye Injury/Trauma
- ☐ Refractive Surgery/LASIK (year)_____
- ☐ Cataract Surgery (year)_____
- ☐ Other Eye Surgery (specify)_____
- ☐ Injections to the Eye
- ☐ Laser Treatments to the Eye
- ☐ Retinal Hole/Tear/Detachment
- ☐ Other (specify)_____
- ☐ **NONE OF THE ABOVE**

Do you currently have:

- ☐ Glaucoma
- ☐ Cataracts
- ☐ Macular Degeneration
- ☐ Diabetic Retinopathy
- ☐ Keratoconus
- ☐ Other (specify)_____
- ☐ **NONE OF THE ABOVE**

MEDICAL HISTORY

Date of last physical exam: _____/_____/_____ Name of Primary Physician: _____
Please list current medications:_____

Do **you** have or have you been treated for:

- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Heart Disease
- ☐ Stroke
- ☐ Diabetes (year diagnosed)_____
- ☐ Thyroid Problems
- ☐ Cancer
- ☐ Arthritis
- ☐ Sinus Problems
- ☐ Allergies to medications (specify)_____
- ☐ Other (specify)_____
- ☐ **NONE OF THE ABOVE**

Do any of your **immediate family members** have:

- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Cancer
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Keratoconus
- ☐ Blindness
- ☐ Color Deficiency
- ☐ Other (specify)_____
- ☐ **NONE OF THE ABOVE**

VISION SOURCE