WELCOME TO OUR OFFICE

PLEASE COMPLETE THE FOLLOWING:

Today's Date:
_____/______/______

PATIENT INFORMATION				
LAST NAME MR MS MISS DR	FIRST NAME	MIDDLE		DATE OF BIRTH
HOME ADDRESS	CITY	STATE	ZIP CODE	SOCIAL SECURITY NUMBER
MOBILE PHONE	ALTERNATIVE	EMAIL ADDRESS		
EMPLOYER (OR SCHOOL)	OCCUPATION (OR GRADE)	HOBBIES/SPECIAL INTERESTS		
HOW DID YOU HEAR ABOUT OUR OFFICE?				
IF THE PATIENT IS UNDER 18 YEARS OF AGE				
NAME OF PARENT/GUARDIAN	PHONE	RELATION TO PATIENT		
EMERGENCY CONTACT				
NAME OF EMERGENCY CONTACT	PHONE	RELATION TO PATIENT		
MEDICAL INFORMATION				
PRIMARY CARE PHYSICIAN	DATE OF LAST PHYSICAL	LAST EYE DOCTOR	DATE OF LAST EYE EXAM	
MEDICAL INSURANCE COVERAGE				
NAME OF MEDICAL INSURANCE	POLICY HOLDER (EMPLOYEE)	POLICY HOLDER BIRTHDATE	RELATION TO PATIENT	
VISION INSURANCE COVERAGE				
NAME OF VISION INSURANCE	POLICY HOLDER (EMPLOYEE)	POLICY HOLDER BIRTHDATE	RELATION TO PATIENT	

DIGITAL RETINAL IMAGING

Hazel Family Eyecare uses advanced technology to monitor early signs of ocular disease within your eye and the layers beneath your retina.

_____ $30.00 - Retinal Photography: This retinal image provides a broad view of the retina to help detect issues with retinal vasculature including retinal hemorrhages, pigment abnormalities as well as signs of macular degeneration. This photo is strongly recommended every year by our doctors.

_____$30.00 - Retinal Scanning: This is a scan of your entire retina providing a detailed analysis of the nine retinal layers and the choroid beneath. This aids in detecting fluid accumulation, central retinal detachments and macular degeneration among other diseases.

_____$45.00 for both services combined - this is the most comprehensive for overall eye health and wellness.

_____No, contrary to recommendation, I am declining the retinal photo and wellness scan.

PRIVACY POLICY

Due to HIPAA laws doctor's offices must keep your information confidential. We have given you our policies regarding how we process your information separately. Please sign below stating you have read our statement. Your signature simply represents we attempted to share with you our HIPAA polices.

Patient/Guardian Signature:____DATE: __________________________

DO YOU CURRENTLY:	ARE YOU INTERESTED TODAY IN:
☐ WEAR GLASSES IF SO, HOW OLD ARE THEY: _____________	☐ PURCHASING NEW EYEWEAR
☐WEAR POLARIZED SUNGLASSES IF SO, HOW OLD ARE THEY: __________	☐ TRYING CONTACT LENSES
☐WEAR CONTACT LENSES IF SO, WHAT BRAND: ______________	☐ LEARNING ABOUT REFRACTIVE SURGERY

YOUR VISUAL FUNCTION: Please check all that apply to you

☐WORK ON COMPUTERS UNDER FLOURESCENT LIGHTING	☐ CONTACT LENSES GET DRY AT LEAST ONCE A DAY
☐ SPEND TIME PLAYING OUTDOOR ACTIVITIES	☐ CONTACT LENSES ARE NOT AS CLEAR AS DESIRED
☐ ENJOY BOATING OR OTHER WATER SPORTS	☐ EXPERIENCE GLARE WHILE DRIVING AT NIGHT
☐ EYES ARE SENSITIVE TO SUNLIGHT	☐ EXPERIENCE EYE STRAIN WHILE USING THE COMPUTER
☐ DRIVE TO OR FROM WORK DIRECTLY FACING THE SUN	☐ READ BOOKS/STUDY FOR LONGER THAN 2 HOURS A DAY
☐ OCCUPATION INVOLVES POSSIBILITY OF EYE INJURY	☐ WOULD LIKE INFO ON THINNER/LIGHTER LENSES

HAVE YOU EVER HAD:

☐ CATARACT SURGERY EYE MUSCLE SURGERY RETINAL SURGERY LASIK SURGERY OTHER EYE SURGERY

IF SO, WHICH EYE WHEN

DO YOU CURRENTLY EXPERIENCE ANY OF THE FOLLOWING

☐ BLURRED VISION	☐ DRYNESS	☐ FLOATERS IN VISION	☐ SANDY FEELING
☐ BURNING	☐ EXCESSIVE TEARING	☐ GLARE SENSITIVITY	☐ SUDDEN VISION LOSS
☐ DOUBLE VISION	☐ EYE PAIN/SORENESS	☐EYE/EYELID INFECTION	☐ LOSS OF SIDE VISION
☐ DROOPING EYELID	☐ FLASHES OF LIGHT	☐ ITCHING	☐ OTHER

VISION HISTORY

Check appropriate boxes if YOU or your blood RELATIVES have:

F = father M = mother S = brother/sister GP = grandparent(s)

	YOU	Family Member			
Amlybopia/lazy eye	☐	F	M	S	GP
Blindness	☐	F	M	S	GP
Cataracts	☐	F	M	S	GP
Color blindness	☐	F	M	S	GP
Crossed/turned eyes	☐	F	M	S	GP
Diabetic retinopathy	☐	F	M	S	GP
Glaucoma	☐	F	M	S	GP
Herpes eye disease	☐	F	M	S	GP
Keratoconus	☐	F	M	S	GP
Macular degeneration	☐	F	M	S	GP
Retinal detachment	☐	F	M	S	GP
Traumatic eye injury	☐	F	M	S	GP
Other eye condition	☐	F	M	S	GP

SOCIAL HISTORY

Do you smoke? NO YES _______pack per day Do you drink? NO YES _______drinks per week

FEMALES, ARE YOU?

☐ Pregnant__________months? ☐ Nursing

PLEASE LIST ALL ALLERGIES:

PLEASE LIST ALL CURRENT MEDICATIONS:

MEDICAL HISTORY

Check appropriate boxes if YOU or your blood RELATIVES have:

F = father M = mother S = brother/sister GP = grandparent(s)

	YOU	Family Member			
Allergies	☐	F	M	S	GP
Arthritis	☐	F	M	S	GP
Blood disease (anemia)	☐	F	M	S	GP
Breathing problems	☐	F	M	S	GP
Cancer	☐	F	M	S	GP
Cardio (heart, carotid)	☐	F	M	S	GP
Cholesterol, high	☐	F	M	S	GP
Collagen (lupus)	☐	F	M	S	GP
Diabetes	☐	F	M	S	GP
Fatigue	☐	F	M	S	GP
Fever blister/cold sore	☐	F	M	S	GP
Gastro (stomach,colon)	☐	F	M	S	GP
Genital,kidney,bladder	☐	F	M	S	GP
Headache/Migrane	☐	F	M	S	GP
Hearing Impairment	☐	F	M	S	GP
Herpes	☐	F	M	S	GP
High Blood Pressure	☐	F	M	S	GP
HIV / Aids	☐	F	M	S	GP
Hormonal/Thyroid	☐	F	M	S	GP
Nose, Sinus Throat	☐	F	M	S	GP
Psych (anxiety, depression)	☐	F	M	S	GP
Resp(asthma,emphysema)	☐	F	M	S	GP
Sex. Transmitted Disease	☐	F	M	S	GP
Skin (acne, eczema)	☐	F	M	S	GP
Weak/numb leg/arm	☐	F	M	S	GP
Weight changes, sudden	☐	F	M	S	GP