New Patient Forms with RP/OCT for everyone

1. Please enter your information.

First Name: _____ Middle Initials: _____ Last Name: _____ Date of Birth: _____

Gender:
○ Female ○ Male

Marital Status:
○ Single ○ Married ○ Domestic Partner ○ Separated ○ Divorced ○ Widowed

Street Address: _____ Apt./Unit #: _____ City: _____ State: _____ Zip Code: _____

Mobile Phone: _____ Home Phone: _____ Work Phone: _____

Email: _____

Preferred contact method:
○ Mobile Phone ○ Home Phone ○ Work Phone ○ Email

Last 4 of SSN# _____ Occupation _____

Vision Insurance _____ Vision Insurance Member Name _____

Vision Insurance ID # _____ Vision Insurance Member Date of Birth and Last 4 of SSN # _____

Medical Insurance _____ Medical Insurance Member Name _____

Medical Insurance ID # _____ Medical Insurance Member Date of Birth _____

2. Eye History

Date of Last Eye Exam _____

Currently Wear Glasses?
○ Yes ○ No

How Old Are Your Current Glasses if You Wear Them? _____

Do You Wear Contacts?
○ Yes ○ No

Type of Contacts You Wear:
☐ Soft ☐ RGP ☐ Scleral

How Often Do You Replace Your Contacts?
☐ Daily ☐ 2 Weeks ☐ Monthly ☐ Other

Have you ever had any eye surgeries/injuries?
☐ Yes ☐ No

What type of surgery/injury, which eye, and when? _____

What is the reason for Today's visit?
☐ Annual Eye Exam ☐ Contact Lens Evaluation ☐ Emergency/ Medical Visit ☐ New Glasses

3. Are you currently experiencing any of the following? Check all that apply.

- ☐ Blurry Vision Distance
- ☐ Blurry Vision Near
- ☐ Burning
- ☐ Discharge
- ☐ Double Vision
- ☐ Dryness
- ☐ Tearing/Watering
- ☐ Eye Pain
- ☐ Floaters or Spots
- ☐ Halos
- ☐ Headaches
- ☐ Itching
- ☐ Light Flashes
- ☐ Light Sensitivity
- ☐ Redness
- ☐ Sandy or Gritty Feeling
- ☐ Eye Infection
- ☐ Light Sensitivity

Other:

_____

4. Have you or a family member experienced, or been treated for, any of the following? If yes, please specify who. Check all that apply.

- ☐ Cataracts _____
- ☐ Crossed Eyes _____
- ☐ Glaucoma _____
- ☐ Lasik or RK _____
- ☐ Macular Degeneration _____
- ☐ Retinal Detachment _____

Other (please explain)

_____

5. Have you or a family member experience, or been treated for, any of the following? Check all that apply. If family, specify who.

Condition	Yes	No	Family	Relationship to you	Type of condition
Allergies					
Arthritis					
Asthma					
Blood/Lymph Disorders					
Cancer					
Diabetes					
Ear/Nose/Throat Conditions					
Gastrointestinal Issues					
Heart Disease					
High Blood Pressure					
High Cholesterol					
Kidney Disease					
Lupus/Autoimmune Condition					
Neurological Condition					
Psychological Condition					
Seizures					
Skin Conditions					
Stroke					
Thyroid Dysfunction					

Any other conditions not listed? Please explain:

_____

6. List medications you are currently taking and the correlating diagnosis:

	Medication	Diagnosis	No Medications
1			
2			
3			
4			

7. Please list any allergies you may have:

	Allergy	No Allergies
1		
2		
3		
4		

8. Eye Health Screenings

Your doctor strongly believes retinal photos to be an important part of your comprehensive eye exam. Retinal photos also allow you to see what your eye looks like - just as the doctor sees it.

Retinal Photo: Fast ultra-widefield photo of the back of your eye (the retina) - Helps detect early signs of diabetes, hypertension, cholesterol, cancers, retinal tears etc - Permanent image to compare year-to-year to track changes - Allows the doctor to dilate less frequently. Your vision will NOT be blurry.

OCT (Optical Coherence Tomography): Non-invasive scan that uses light to create a detailed, cross-section image of the retina. Similar to an MRI for your eye - Detects/Monitors early retinal changes of macular degeneration, glaucoma, diabetic eye disease etc - Helps the doctor diagnose problems before symptoms appear, when treatment is most effective. Your vision will NOT be blurry

Dilation: Eye drops used to enlarge the pupils temporarily, allowing the doctor to see the retina - Will experience light sensitivity, and blurry vision for about 4-6 hours

Choose One Screening:

- ○ Optomap Retinal Imaging: Co-Pay of $39 (depending on insurance)
- ○ OCT (Optical Coherence Tomography) Scan: $95 ○ Optomap + OCT (bundle): $59
- ○ Dilation (included with eye exam)

9. Is there anything else you would like our office to know before your visit?