

WELCOME TO WHITBOURNE EYE CARE

We are pleased to welcome you to our practice. All major health insurers and Medicare now require us to obtain in-depth patient medical history information. Please take a few minutes to fill out this form as completely as you can. If you have any questions, we will be glad to help you. All information is kept strictly confidential. Please follow the numbers starting with 1.

1. Today's date
 _____ / _____ / _____

Patient Information

2. Patient's Name		Date of Birth / /		Gender M F		Age	
Street Address			Apt. No.	City		State	Zip
Home Tel. No.		Work/Cell. No.		Employer		Occupation	
Marital status (circle) Married Single		Social Security Number		If we may contact you by e-mail, please tell us your e-mail address:			
3. Date of last EYE EXAM / /		Name of previous eye doctor		4. Date of last PHYSICAL / /		Name of physician	
5. If a person other than the patient is responsible for this account and/or the patient is a minor, please tell us the following information: a. Relationship to patient:							
b. Name of person responsible for account				6. IMPORTANT! How did you hear about us? <input type="radio"/> Friend/Relative <input type="radio"/> Ad <input type="radio"/> Internet <input type="radio"/> Other			
Street Address			Apt. No.		If referred, please list the name of friend, relative or doctor:		
City		State	Zip Code				

Medical History

7. Reason for today's visit <input type="checkbox"/> routine annual exam <input type="checkbox"/> need new glasses <input type="checkbox"/> lost or broken glasses <input type="checkbox"/> contact lenses <input type="checkbox"/> eye discomfort/irritated <input type="checkbox"/> injury/infection <input type="checkbox"/> interested in laser vision correction <input type="checkbox"/> other	
8. Please list any medications you are currently taking (including "natural" and eye drops): _____	
9. Please check any of the following related to your eyes Condition Blindness..... <input type="radio"/> Cataract..... <input type="radio"/> Crossed eyes..... <input type="radio"/> Lazy eye..... <input type="radio"/> Itching/burning..... <input type="radio"/> Dryness..... <input type="radio"/> Eye infection..... <input type="radio"/> Eye injury..... <input type="radio"/> Droopy lids..... <input type="radio"/> Glaucoma..... <input type="radio"/> Macular degeneration..... <input type="radio"/> Retinal detachment..... <input type="radio"/> Floaters/flushes in vision... <input type="radio"/> Other eye disease..... <input type="radio"/>	10. Do you wear glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what type? <input type="checkbox"/> single vision <input type="checkbox"/> bifocal <input type="checkbox"/> trifocal <input type="checkbox"/> progressive <input type="checkbox"/> don't know 11. Do you wear contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what type? <input type="checkbox"/> soft disposables <input type="checkbox"/> gas perm <input type="checkbox"/> toric <input type="checkbox"/> bifocal <input type="checkbox"/> other 12. Are you interested in contacts? <input type="checkbox"/> Yes <input type="checkbox"/> No 13. Have you ever had Lasik or refractive surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when? _____ / _____ / _____ 14. Have you ever had eye surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe: _____ 15. Are you pregnant and/or nursing? <input type="checkbox"/> Yes <input type="checkbox"/> No

<Please Turn This Form Over and Complete Side Two>

16. Are you allergic to any medications? Yes No If yes, please list: _____

17. How many hours a day do you work on a computer? _____

Review of Systems

Do you currently, or have you ever had any serious problems in the following areas?

DISEASE/CONDITION	YES	NO	DISEASE/CONDITION	YES	NO
DIABETES	<input type="checkbox"/>	<input type="checkbox"/>	BLOOD	<input type="checkbox"/>	<input type="checkbox"/>
HIGH BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	ENDOCRINE (Thyroid)	<input type="checkbox"/>	<input type="checkbox"/>
NEUROLOGICAL (Headaches)	<input type="checkbox"/>	<input type="checkbox"/>	EARS, NOSE, MOUTH, THROAT (Allergies)	<input type="checkbox"/>	<input type="checkbox"/>
CHOLESTEROL	<input type="checkbox"/>	<input type="checkbox"/>	RESPIRATORY (Breathing problems)	<input type="checkbox"/>	<input type="checkbox"/>
EPILEPSY/SEIZURES	<input type="checkbox"/>	<input type="checkbox"/>	CARDIOVASCULAR	<input type="checkbox"/>	<input type="checkbox"/>
CANCER	<input type="checkbox"/>	<input type="checkbox"/>	GASTROINTESTINAL	<input type="checkbox"/>	<input type="checkbox"/>
SKIN	<input type="checkbox"/>	<input type="checkbox"/>	MUSCULOSKELETAL (Arthritis)	<input type="checkbox"/>	<input type="checkbox"/>
LUPUS	<input type="checkbox"/>	<input type="checkbox"/>	MENTAL (Depression, Anxiety)	<input type="checkbox"/>	<input type="checkbox"/>
GENITOURINARY	<input type="checkbox"/>	<input type="checkbox"/>	OTHER: _____		

If you answered YES to any of the above or are currently under the care of a physician for any condition not listed above, please explain:

Family History

Does anyone in your family (parents, grandparents, sibling, children: living or deceased) have or had any serious problems in the following areas?

DISEASE/CONDITION	YES	NO	DISEASE/CONDITION	YES	NO
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Cataract	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Retinal Detachment/Disease	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid/Gland Disease	<input type="checkbox"/>	<input type="checkbox"/>	Blindness	<input type="checkbox"/>	<input type="checkbox"/>
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____					

Social History *This information is kept strictly confidential. Please answer all questions that apply.*

	YES	NO	
Do you drive?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, do you have visual difficulty when driving? <input type="checkbox"/> yes <input type="checkbox"/> no
If yes, please describe: _____			
Do you use tobacco products?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you use illegal drugs?	<input type="checkbox"/>	<input type="checkbox"/>	

IMPORTANT INFORMATION ABOUT DILATION

As part of your complete eye examination, your pupils will be dilated. This involves the placement of a few drops of medicine into each eye. After a period of about twenty minutes, the pupil (black part of eye) gets very large or dilates. This allows the doctor to get a thorough look inside the eye and is necessary for diagnosing cataracts, glaucoma, and other eye diseases. The side effects of dilation are blurry near vision and sensitivity to light. The effects wear off in about four hours but occasionally last longer for some people. Should you wish to forego dilation of your eyes or your child's eyes on this visit, please check in one of the boxes and sign in the space provided below. If dilation is rescheduled there is a nominal fee for the office visit.

I refuse to have my eyes dilated I refuse to have my child's eyes dilated

I am aware that without this procedure certain eye conditions and diseases cannot be determined.

Signature of Patient/Parent _____

Date _____

OFFICE USE ONLY	Patient/Parent agreed to dilation <input type="checkbox"/> yes <input type="checkbox"/> no	Medical history reviewed <input type="checkbox"/> yes <input type="checkbox"/> no
Doctor's Signature _____	Date _____	

WHITBOURNE EYE CARE

We are happy to assist you in the filing of your insurance claim. Vision insurance only covers routine, uncomplicated examinations – not medical procedures. By providing your medical card you are authorizing your doctor to do tests that are necessary for the management of your condition found during your examination. Your doctor will discuss what tests are being performed before proceeding, but your doctor is not responsible for knowing what your insurance pays for or does not pay for. She may help you but if there is any doubt, it is advisable to contact your insurance company about the procedures prior to them being performed. Your doctor may need to do further testing and these tests are medical procedures. Your plan may require a pre-authorization or referral. It is your responsibility to see that you obtain this information. If your insurance will not pay the anticipated amount or your insurance pays you directly, we ask that you pay your balance promptly. We require payment at the time of service and that includes insurance co-pays. Co-pays are due for each visit you make to our office. There are no exceptions since we are under strict rules by your insurance company. We accept cash, personal checks, and certain credit cards. Please be aware that this office will not provide reimbursement for insurance presented after the date of service.

Insurance Information

Who is responsible for this account?
(please specify person): _____

Medical Insurance Company _____

Vision Insurance Company _____

Subscriber's Name: _____

Subscriber's date of birth: _____ Member ID No. _____

Relationship to patient: _____

Records Release and Payment Authorization

I authorize the eye doctor to release any information including the diagnosis and records of treatment or examination rendered to me or my child during the period of such eye care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the eye doctor. I understand that my eye care insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Name of Patient

Signature of Patient (or parent if a minor)
(Lifetime signature)

Date

WHITBOURNE EYE CARE

Visual Field Testing

A visual field test is used to determine the functioning of the optic nerve and retina (lining of eye) by testing the peripheral vision (side vision) and is an important part of your comprehensive eye exam.

The **screening** visual field test is a quick, computerized test which can be used to detect disease such as

- Strokes in the eye
- Glaucoma
- Neurological disease/headaches
- Unexplained vision loss
- Vascular disease
- Retinal disease
- Brain tumors

It is highly recommended for all patients.

The fee for this test is \$15.00 and is not covered by your insurance.

- I would like to have the screening test done and agree to pay the fee of \$15
- I would not like to have the test done at this time

signature or signature of parent/guardian

Date

Many times a more detailed version of the test is required. This picks up more subtle changes in the eye and optic nerve therefore giving the doctor valuable information about the health of your eyes. You will be informed if this is necessary.