

Spec Rx:  
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DVA (cc/sc)  
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NVA (cc/sc) Blood Pressure \_\_\_\_/\_\_\_\_  
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### Distinct Eye Care Welcome to Our Office

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M.I. \_\_\_\_\_

Age \_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex (M/F) \_\_\_\_ Parent/Guardian's Name \_\_\_\_\_

**So that we may contact you if needed, please list:**

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_

Home Phone (\_\_\_\_)\_\_\_\_-\_\_\_\_ Cell Phone (\_\_\_\_)\_\_\_\_-\_\_\_\_ Work Phone (\_\_\_\_)\_\_\_\_-\_\_\_\_

Email address \_\_\_\_\_ Patient's occupation \_\_\_\_\_

Emergency contact's name \_\_\_\_\_ Phone number \_\_\_\_\_

Will your visit be self-pay today?  Yes  No (If No, please fill out the box below)

INSURANCE INFORMATION		
Vision Plan	Primary Medical Insurance	Secondary Medical Insurance
Company	Company	Company
Phone #	Phone #	Phone #
Policy/ID #	Policy/ID #	Policy/ID #
Group #	Group #	Group #
Primary Policy Holder	Primary Policy Holder	Primary Policy Holder
Employer	Employer	Employer
Social Security #	Social Security #	Social Security #

How did you hear about us?  Family/Friends  Insurance  Internet  Other \_\_\_\_\_

#### MEDICAL HISTORY

Date of last eye exam \_\_\_\_/\_\_\_\_/\_\_\_\_ Eye doctor's name \_\_\_\_\_

Date of last medical exam \_\_\_\_/\_\_\_\_/\_\_\_\_ Doctor's name \_\_\_\_\_

Do you wear contact lenses? \_\_\_\_ If so, what type? \_\_\_\_\_

Are you interested in contact lenses? \_\_\_\_ If so, what type? \_\_\_\_\_

Do YOU currently, or have you ever had any problems with the following:

OCULAR HEALTH	YES	NO	MEDICAL HEALTH	YES	NO
Blurry vision	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes (Type: I or II)	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Tired when reading	<input type="checkbox"/>	<input type="checkbox"/>	Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Redness	<input type="checkbox"/>	<input type="checkbox"/>	Heart disease	<input type="checkbox"/>	<input type="checkbox"/>
Dryness/Watering	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>	Stomach ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	Cancer (Type: _____)	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>
Floaters	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Flashing lights	<input type="checkbox"/>	<input type="checkbox"/>	Depression/Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Eye infections	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Eye surgeries	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Eye injuries	<input type="checkbox"/>	<input type="checkbox"/>	Oral/Genital Herpes	<input type="checkbox"/>	<input type="checkbox"/>
Lazy eye	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Other:			Other:		

Are you currently pregnant/nursing?  Yes  No

Please list your **MEDICATIONS/VITAMINS:** ( None taken)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list any and all **ALLERGIES:** ( None Known)

\_\_\_\_\_  
\_\_\_\_\_

Do you smoke?  Yes  No Please list any **HOBBIES** you have: \_\_\_\_\_

Please note any **FAMILY HISTORY** for the following conditions:

	Yes	No	Family Member		Yes	No	Family Member
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>		Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	
Cataract	<input type="checkbox"/>	<input type="checkbox"/>		Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>		High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	
Retinal disease	<input type="checkbox"/>	<input type="checkbox"/>		Sickle Cell	<input type="checkbox"/>	<input type="checkbox"/>	
Lazy eye	<input type="checkbox"/>	<input type="checkbox"/>		Other:	<input type="checkbox"/>	<input type="checkbox"/>	
Cancer	<input type="checkbox"/>	<input type="checkbox"/>		Other:	<input type="checkbox"/>	<input type="checkbox"/>	
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>		Other:	<input type="checkbox"/>	<input type="checkbox"/>	

**DILATION**

Dilation of the eyes involves the instillation of eye drops to open the pupils. This allows the doctor to check the health of the back of the eye (the retina). Dilation is necessary to fully assess the health of the eyes. Dilation can detect vision-threatening conditions such as holes, tears, cataract, and glaucoma. Also, dilation can determine the visual effects of systemic diseases such as diabetes, high blood pressure, and cholesterol. Dilation is strongly recommended for patients with these diseases, as they can cause vision loss. Side effects of dilation may include blurry vision at near and some light sensitivity, which can last for a few hours. **There is NO additional fee for dilation.** PLEASE CHECK BELOW:

- YES, I want my eyes to be dilated.
- NO, I do not want my eyes to be dilated.
- I would like to discuss this procedure with the doctor.

**RETINAL PHOTOGRAPHS**

Retinal Photos (images of the back of the eye) **are highly recommended by Dr. Reese for every single patient.** This image will help your doctor to thoroughly assess and monitor your ocular health, and detect any retinal or ocular health problems that you may have. Using this scan, we can see retinal problems such as Cancer, Macular Degeneration, Glaucoma, Retinal Holes, Retinal Detachments, Diabetes, High Blood Pressure, and a host of other pathologies.

PLEASE CHECK BELOW:

- YES, I want the image taken. The fee is \$39.00
- YES, I want the image taken and dilation. The fee is \$39.00.
- NO, thanks. Let me speak to the doctor about dilation this year.

Patient/Parent/Guardian signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES**

(Please see the laminated form on the clipboard)

The law requires that Distinct Eye Care make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that I have read or had explained to me Distinct Eye Care’s Notice of Privacy Practices and:

- I AGREE to continue my care with Distinct Eye Care under said terms.
- I DECLINE the terms, but wish to continue my care with Distinct Eye Care under the terms of Distinct Eye Care’s privacy policies. (Please briefly list any term(s) you disagree with) \_\_\_\_\_
- The Notice of Privacy Practices could not be read due to the emergent nature of care or other reason described as \_\_\_\_\_.

**Please list all persons who may have access to your health care information (i.e. your spouse, child, etc):**

Name	Relation
_____	_____
_____	_____
_____	_____

I HAVE READ AND UNDERSTAND THE ABOVE PARAGRAPHS. I AM SIGNING BELOW VOLUNTARILY.

Patient/Parent/Guardian signature \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

If you are signing as a personal representative of the patient, please indicate your relationship.

Name of Representative	Relationship to Patient

**ACKNOWLEDGEMENT OF NON-REFUNDABLE SERVICES & INSURANCE AUTHORIZATION**

I understand that any and all services I receive at Distinct Eye Care are non-refundable.

I certify that the information given by me in applying for insurance payment is true and correct. I authorize my doctor and the office staff to act as my agent(s) in helping me obtain payment by my insurance. I authorize payment of these benefits be made directly to Distinct Eye Care, Inc. on my behalf for any services provided. I authorize any holder of my medical information to determine the insurance benefits for related services. My signature authorizes release of the above medical information to the insurer or agency given. In the event that my insurance does not cover any portion of this visit, I acknowledge that I am responsible for any co-pays and/or payment for services rendered.

Patient/Parent/Guardian signature \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_