Spec Rx:		DVA (cc/sc)	NVA (cc/sc)	Blood Pressure: _____/_____
OD:		10/	20/	
OS:		10/	20/	
Add: +	SV			

This Space is for Office Staff Use Only

Distinct Eye Care

Thank You for Returning to Our Office

Date ____/____/____

Last Name _____ First Name _____ M.I. _____

Age _____ Date of Birth ____/____/____ (For Minors) Parent/Guardian's Name_____

Email Address_____

Has your ADDRESS or PHONE NUMBER changed? ☐ NO ☐ YES (If so, please update the information below)

Address _____ City _____ State _____ Zip _____

Cell (_____)_____-_____ Home Phone (_____)_____-_____ Work/Alternate (_____)_____-_____

Please list ALL PERSONS WHO MAY HAVE ACCESS TO YOUR HEALTH CARE INFORMATION (i.e. your spouse, your child, etc.):

Name	Relation
_____	_____
_____	_____
_____	_____

I authorize the above person(s) to have access to my health care information at Distinct Eye Care, INC.
I understand that any and all services I receive at Distinct Eye Care are **non**-refundable.

*Patient/Parent/Guardian signature_____Date___/___/___

Please tell us about your MEDICAL information:

	Yes	No	Explain		Yes	No
Diabetes	☐	☐	Type I or II	Arthritis	☐	☐
High Blood Pressure	☐	☐		Oral/Genital herpes	☐	☐
Cholesterol	☐	☐		Depression/anxiety	☐	☐
Heart disease	☐	☐	(Type_____)	Asthma	☐	☐
Thyroid Disease	☐	☐		Pregnant/nursing	☐	☐
Cancer	☐	☐	(Type_____)	Other:		
HIV/AIDS	☐	☐		Other:		

Do you smoke? ☐ Yes ☐ No Date of **LAST MEDICAL EXAM** with blood work: _____

Please list your **MEDICATIONS/VITAMINS:** (☐ None taken) (☐ See List-Please hand the list to the receptionist)

_____

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

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 ____/____/____