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

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	☐	☐	Diabetes (Type: I or II)	☐	☐
Double Vision	☐	☐	High blood pressure	☐	☐
Tired when reading	☐	☐	Cholesterol	☐	☐
Redness	☐	☐	Heart disease	☐	☐
Dryness/Watering	☐	☐	Thyroid	☐	☐
Itching	☐	☐	Stomach ulcers	☐	☐
Cataract	☐	☐	Cancer (Type:_____)	☐	☐
Glaucoma	☐	☐	Sinus problems	☐	☐
Floaters	☐	☐	Asthma	☐	☐
Flashing lights	☐	☐	Depression/Anxiety	☐	☐
Eye infections	☐	☐	HIV/AIDS	☐	☐
Eye surgeries	☐	☐	Hepatitis	☐	☐
Eye injuries	☐	☐	Oral/Genital Herpes	☐	☐
Lazy eye	☐	☐	Arthritis	☐	☐
Other:			Other:		

Are you currently pregnant/nursing? ☐ Yes ☐ No Do you smoke? ☐ Yes ☐ No

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

_____

_____

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

_____

Please list any **HOBBIES** you have:_____

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

	Yes	No	Family Member		Yes	No	Family Member
Glaucoma	☐	☐		Diabetes	☐	☐	
Cataract	☐	☐		Heart Disease	☐	☐	
Macular Degeneration	☐	☐		High Blood Pressure	☐	☐	
Retinal disease	☐	☐		Sickle Cell	☐	☐	
Lazy eye	☐	☐		Other:	☐	☐	
Cancer	☐	☐		Other:	☐	☐	
Thyroid Disease	☐	☐		Other:	☐	☐	

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 the day of your complete eye exam.** 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
☐ NO. I do NOT want the image taken. I do understand this image helps my doctor examine my eyes more thoroughly.

VISUAL FIELD WELLNESS SCREENING

Visual Field Screenings are recommended to evaluate your peripheral vision. They help us determine any subtle vision loss that cannot be determined with a routine vision exam alone. This test is especially recommended for patients with headaches or any type of visual disturbance.

PLEASE CHECK BELOW**:**
☐ YES, I want the Visual Field Wellness test. The fee is $25.00 ☐ NO, thank-you.

Patient/Parent/Guardian signature_____ Date ____/____/____

PATIENT PORTAL
&
CONTACT LENS EXAM AGREEMENT

You have access to your glasses and contact lens prescriptions at any time via our online patient portal. Your user name and temporary password will be on your invoice at checkout or will be emailed to you. If you have difficulty accessing your prescriptions via the portal please contact our office. You may change your temporary password at any time by logging into the portal under "Account."

There is a separate charge for a contact lens prescription. This is the contact lens exam/fitting fee. Your insurance may or may not cover this fee. Our staff will inform you at check-in how much your estimated cost for this exam will be. You have two months to return to our office for a contact lens follow-up if one is advised without any additional fee. After two months, there will be an extended contact lens fee.

Please sign acknowledgement of your understanding of these two paragraphs below.

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) _____
_____.

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, materials obtained, and products purchased.

Patient/Parent/Guardian signature_____Date___/___/___