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 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
☐ 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 ____/____/____

Please complete the back of the form

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.

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___/___/___

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.

*Patient/Parent/Guardian signature_____Date___/___/___

Please complete the back of the form