Confidential Medical History

Name: _____ Email: _____

Address: _____ Phone: _____

City/State: _____ Zip: _____ Height: _____ Weight: _____

Date of Birth: _____ ☐ Male ☐ Female Occupation: _____

What is the main reason for today's exam? _____

***For returning patients:** If there is no change in your medical history since your last visit, please acknowledge by signing below and complete the back page. Otherwise, please help us update our records by completing the form in its entirety.*

Patient Signature: _____ Date: _____

Ocular History / Family History / Review of Systems

Do you currently wear glasses? ☐ Yes ☐ No If Yes, how old is your current pair? _____

Do you currently wear contacts? ☐ Yes ☐ No If Yes, what brand do you wear? _____

Have you had your eyes dilated? ☐ Yes ☐ No If Yes, when were you last dilated? _____

Have you had LASIK/refractive surgery? ☐ Yes ☐ No If No, are you interested? _____

Do you currently have, or have you ever had, any problems in the following areas? Mark the box for yes.

☐ Blurred vision at distance	☐ Blurred vision at near	☐ Double vision	☐ Loss of vision
☐ Floaters	☐ Eyestrain/Fatigue	☐ Eye pain	☐ Eye disease
☐ Flashes of light	☐ Dry/Sandy eyes	☐ Cataracts	☐ Eye injury
☐ Itchy eyes	☐ Light sensitivity	☐ Glaucoma	☐ Eye surgery
☐ Red eyes	☐ Variable vision	☐ Eye turn/Lazy eye	☐ Eye infection

Do you have any blood relatives with the following? Mark the box for yes.

☐ Glaucoma	Who: _____	☐ Macular degeneration	Who: _____
☐ Retinal disease	Who: _____	☐ Eye turn/Lazy eye	Who: _____
☐ Diabetes	Who: _____	☐ Cancer	Who: _____
☐ High blood pressure	Who: _____	☐ Heart disease	Who: _____

When was your last physical or medical check up? _____ Primary Care doctor's name: _____

Do you have problems with any of these systems? *(Please circle all that apply)*

Eyes	Y / N	Psychiatric	Y / N	Musculoskeletal	Y / N	Nervous	Y / N
Allergic/Immunologic	Y / N	Ear/Nose/Throat	Y / N	Genitourinary	Y / N	Integumentary	Y / N
Cardiovascular	Y / N	Endocrine	Y / N	Blood/Lymph	Y / N	Gastrointestinal	Y / N
Respiratory	Y / N						

Explanation of ocular or health history: _____

_____

_____

Are you currently taking any medications? ☐ Yes ☐ No Which ones? _____

Are you allergic to any medications? ☐ Yes ☐ No Which ones? _____

Are you pregnant or nursing? ☐ Yes ☐ No

Social History

Do you drive? ☐ Yes ☐ No

Do you use tobacco products? ☐ Yes ☐ No

Do you consume alcohol? ☐ Yes ☐ No

Patient Signature: _____ Date: _____

Dilated Fundus Exam

A dilated eye exam is recommended every one to two years for all patients. Dilation is recommended *every year* for patients with diabetes, high blood pressure, cholesterol, heart problems, headaches or any other medical conditions.

Patients with high prescriptions (over -4.00), symptoms of flashes and floaters and history of blunt trauma to the head should have this test to rule out any retinal complications. In addition, children may also need to be dilated to better determine their eyeglasses prescription.

The doctor will use drops to dilate the pupils, which takes approximately 20 minutes depending on the individual. Most common side effects will include blurry near vision, glare and sensitivity to light that will last 3 to 4 hours.

Please check one:

☐ I would like to get my eyes dilated today.
☐ I would like to schedule a time to come back for the dilation.
☐ I do not want my eyes dilated (see below)

In refusing to have my eyes dilated, I understand that I am assuming all risks associated with failure to diagnose eye conditions due to lack of information, which may have been provided by this test.

Please initial here: _____

Retinal Photography and iWellness Screening

In addition to dilation, our doctors highly recommend having retinal photography and digital scan in your patient file, especially if you are >40 years old, have a family history of eye disease, or a history of diabetes/high blood pressure/high cholesterol. The doctor will review these tests with you today, and they will become part of your permanent patient record.

Retinal photography and iWellness are $38 each, or $60 together. This co-pay is typically not covered by your medical or vision insurance unless being used to actively follow disease.

Please check one:

☐ I would like to have **retinal photography/ iWellness screening** done today. **(circle one)**
☐ I would like to have both tests done today.
☐ I decline to take advantage of these procedures today.

Notice of Privacy Practices

In the course of providing services, North Bay Vision Center creates, receives, and stores health information that identifies patients. It is often necessary to use and disclose this information in order to administer treatment, to obtain payment for services, and to conduct healthcare operations within this office. The Notice of Privacy Practices describes these uses and disclosure in detail. I acknowledge that I have reviewed the Notice of Privacy Practices from North Bay Vision Center, and that a copy can be provided upon request.

I understand that I am financially responsible for all fees for services provided. If additional tests/services are required (i.e.: contact lens services, medical eye services), these may have additional charges not necessarily covered by insurance associated with them. All fees and insurance co-pays will be collected by the end of the visit.

Patient Signature: _____ Date: _____

PATIENT REGISTRATION

Please Print Date _____

Name _____
(last) (first) (M.I.)

Birthdate _____ Age _____ Sex M_____ F _____

Single ____ Married ____ Other ___ Social Sec. #xxx-xx-_____

Residence Address _____

City _____ Zip _____

Phone _____ Cell _____

E-Mail _____

Occupation _____ Bus. Phone _____

Employer _____How long _____

Spouse/parent occupation _____

Employer _____How long _____

If Student- Grade _____ School _____

Names/ages of children at home _____

_____

Referred by _____

Person responsible for this account _____

Office Financial Policy:
Payment for professional services should be made when services are rendered
Deposit of 50% on prescription orders and balance paid in full upon delivery.

Please indicate method of payment:

Cash _____ Check _____ Charge card (Visa, M/C) _____

Vision Plan name _____

Major Medical Insurance _____

Signed _____

ACKNOWLEDGEMENT OF REVIEW

I acknowledge that I reviewed a copy of:
North Bay Optometric Vision Center's
Notice of Privacy Practices

Patient name _____

Signature _____

Date _____