Thank you for allowing us to treat you! **Please Print**. Circle your answer when appropriate.

Name: _____ Date: _____

Street Address: _____ Apt # _____ City_____ State _____ Zip _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-Mail Address: _____

Date of Birth: _____ / _____ /_____ Sex: **M** **F** SS#: _____ - _____ - _____

Employer (or School): _____ Occupation (or Grade): _____

Last Medical Exam _____ Dr.'s Name: _____ Dr.'s Number: _____

Last Eye Exam _____ Dr.'s Name: _____

Women: Are you pregnant or nursing? **N** **Y** Due Date: _____

MEDICAL HISTORY

What is the reason for your visit today?

_____

Have you had: crossed eyes, lazy eye, drooping eye lid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections, eye injuries, or eye surgeries?

N / **Y** If yes, please explain _____

Are you being treated for a medical condition? **N** **Y**

If yes, please explain _____

Do you have allergies to any medications? If yes, please list: _____

List all medications you are taking

_____

_____

Describe your daily computer use: ___ Extensive (5+ hrs) ___ Moderate (1-4 hrs) ___ Low 1hr or less

Do you wear contacts? **N** **Y** If yes, what type? (circle which applies)

Soft Daily Wear Disposable Extended wear Toric Monovision Multifocal RGP (rigid gas permeable)

Brand, if known _____ Are they comfortable? **N** **Y**

How old are the contacts you are currently wearing? _____How often do you replace your lenses? _____

SOCIAL HISTORY

Do you: Use tobacco products? **N** **Y** Drink alcohol **N** **Y** Use illegal drugs? **N** **Y**

Hobbies/sports _____

FAMILY HISTORY

Is there any family medical history of any of the following? (If yes, please list their relationship to you)

CONDITION	NO	YES	WHO?	CONDITION	NO	YES	WHO?
Glaucoma	☐	☐	_____	Diabetes	☐	☐	_____
Cancer	☐	☐	_____	Macular Degeneration	☐	☐	_____
Heart Disease	☐	☐	_____	High Blood Pressure	☐	☐	_____
Thyroid Disease	☐	☐	_____				

Other _____

DIAGNOSTIC TESTING

We strongly encourage all our patients to have the following tests performed. They are especially important for anyone over 35 years of age, patients who have high blood pressure, diabetes, retinal problems, headaches, floaters, flashing lights, a strong prescription, or a family history of eye disease. These tests are in addition to a wellness examination. Your doctor may determine one or both of these tests necessary for your comprehensive eye health examination. A medical condition may require these procedures and allow for your General Medical Insurance to cover a portion of the fees (the patient is responsible for the remaining balance). If there is no General Medical Insurance and/or no medical diagnosis, the fees for screening are due at the time of service.

Please INITIAL the following, if applicable:

Digital Retinal Photography

Photographs of the inside of the eye can assist the doctor with the early detection of Macular Degeneration, Glaucoma, Cataract, Diabetes, High Blood Pressure, Optic Nerve Disease, etc.

_____ ***"I approve an extra $40 fee for this procedure (if not covered by insurance)."***

INFORMED CONSENT OF TREATMENT

"I consent to treatment by Distinctive Vision Care, PLLC."

_____ _____ _____

Patient signature *Guardian Signature if under 18* *Date*

(Your signature denotes your understanding of informed consent)

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA PRIVACY PRACTICES

I acknowledge that I have been informed of the Patient Privacy Policy of this office in accordance with the Federal Health Insurance Portability and Accountability Act (HIPAA).

_____ _____ _____

Patient signature *Guardian Signature if under 18* *Date*

INSURANCE INFORMATION

Policy Holder's Name: _____ Date of Birth: _____ / _____ /_____

SS# or ID # _____ Relationship to Insured: Self / Spouse / Child / Other

I authorize Distinctive Vision Care, PLLC to use "SIGNATURE ON FILE" in actual signature on insurance claim forms.

Assignment of Benefit

I authorize payment of medical benefits to Distinctive Vision Care, PLLC for services rendered. I understand that I am financially responsible for all Charges not paid by my insurance plan.

*Sign*_____ *Date* _____

Release of Information

I authorize the release of information regarding my treatment or condition in order to obtain payment for Professional Services.

*Sign*_____ *Date* _____