

Welcome Back!

***In order to verify that our records are current, please update the following information.**

Name: _____		DOB: _____	
Mailing Address, City, State and Zip: _____			
Cell Phone #: _____	Home Phone #: _____	Work Phone #: _____	Other: _____
Preferred daytime contact? <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work <input type="checkbox"/> Email <input type="checkbox"/> Text Message			
Medical Insurance Name: _____ ID#: _____ Group#: _____ Primary Insured: _____		Vision Insurance Name: _____ ID#: _____ Group#: _____ Primary Insured: _____	
EMAIL ADDRESS: _____			
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Child <input type="checkbox"/> Other			
Employer and Occupation: _____			
Employment Status: <input type="checkbox"/> Employed – full time <input type="checkbox"/> Employed – part time <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired			
<input type="checkbox"/> Student School & Grade: _____			
Main Reason for Today's Visit: <input type="checkbox"/> Annual Exam <input type="checkbox"/> Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Medical Visit <input type="checkbox"/> Other			
Changes in Health since last visit? <i>Any hospitalizations/surgeries?</i> _____			
Primary Care Physician: Name & Phone # _____			
Are you currently? <input type="checkbox"/> Pregnant <input type="checkbox"/> Diabetic <input type="checkbox"/> Newly diagnosed with any other condition: _____			
Do you have a preference in Doctor? <input type="checkbox"/> None <input type="checkbox"/> Dr. Wilkinson <input type="checkbox"/> Dr. Ohan <input type="checkbox"/> Dr. Middleton <input type="checkbox"/> Dr. Tran			

If returning patient is a minor:

Parent Guardian names: _____ Relationship: _____

Contact #: _____

ATTENTION: New State and Federal Regulations require that our office identify each patient with a photo ID. Please present your driver's license or picture ID if available. If you do not have a photo ID, please let the front desk staff know so that we may update your file with an electronic photograph.

Assignment of Benefits: I authorize payment of medical benefits to Vision Trends Eye Care for professional services rendered.

Release of Information: I authorize the release of my medical information necessary to process my insurance claim.

Patient/ Representative Signature (Parent or guardian if patient is a minor)

Date

Retinal Examination

It is recommended for every patient to have a thorough retinal evaluation each year.

At Vision Trends Eye Care, we offer two (2) methods to achieve the recommended thorough retinal evaluation. The standard dilated retinal evaluation, or the OPTOMAP.

- 1) **OPTOMAP** is a digital image of the retina. The OPTOMAP is offered for a separate fee of \$30.00, and is not covered by insurance at this time. With the OPTOMAP, there are no side-effects.

- 2) **Standard dilated retinal evaluation**, whereby your eyes are dilated and via special lenses, a detailed view of the posterior of the eye (retina) is observed. With the dilation, most patients will experience the following side-effects:
 - light sensitivity (post-mydratic eyewear, or special sunglasses, are required outdoors)
 - blurred vision (usually only affecting near vision) for three to four hours. Most patients do not experience blurred vision for distance; therefore, most patients do not have difficulty with driving.

****Please note that not all patients experience side-effects in the same degree. Your reaction to the standard dilation may be more or less severe than other patients.*

The preferred method is the **OPTOMAP**, as the image is permanently retained, a view is made of the retina at once, and dilation is not necessary.

Please choose how you would prefer to obtain your retinal evaluation:

(If **PREGNANT** and/or nursing, dilation will NOT be done at this time or unless you have chosen the OPTOMAP. Please select box #3.)

- I choose the **OPTOMAP** retinal imaging and understand the fee is **\$30.00 not covered by insurance.**
- I choose to be dilated for standard retinal evaluation and will not be charged any additional fees.
- I would rather return for a dilated retinal evaluation at another time.
- I prefer not to have a retinal evaluation today.

Patient's Name (please print) _____

Patient or Parent/Guardian Signature

Date