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PATIENT ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of Vision Trends Eye Care's Notice of Privacy Practices, or that it was made available to me to receive, or explained to me by VTEC staff.

I consent to the use and disclosure of my personal health information by Vision Trends Eye Care for treatment, insurance, billing, and healthcare operations as outlined in the Notice of Privacy Practices. Knowing that standard e-mail and text communication may not be totally secure, I still consent to communication from my doctor or staff through my standard e-mail and texting devices.

_____ _____

Patient Name Date

_____ _____

Signature of Patient or Legal Guardian Relationship to Patient

Names of any individuals you authorize to make inquiries into your medical history, insurance information or billing history:

Name: Relationship to Patient:

_____

_____

_____

WELCOME

We would like to welcome and thank you for choosing our office for your vision care. We look forward to serving you and are confident that you will find your experience with Vision Trends Eye Care to be a pleasant one! Please take a moment to tell us a little about yourself.

Last Name	**First Name**	**Middle Name**

Mailing Address, City, State, Zip:	
Gender: □ **Male** □ **Female** **Birthdate:** ____/____/____	**Social Security #:** ____/____/____ **Marital Status:** □ **Single** □ **Married** □ **Divorced** □ **Widowed**

Cell Phone #:	**Home Phone #:**	**Work Phone #:**	**Other Phone #:**

Preferred Daytime Contact: □ Home □ Cell □ Work □ Email □ Text Message

EMAIL ADDRESS:

Occupation & Employer/ School & grade:	**Employment Status:** □ Employed □ Unemployed □ Retired □ Student □ Disabled

PARENT/GUARDIAN Information (if minor):

Please tell us your relationship to the patient? □ Parent □ Grandparent □ Other: _____
Has the child ever been prescribed glasses or contacts in the past? □ **Yes** □ **No**
Does the child wear glasses or contacts now? □ **Yes** □ **No**
List any major medical condition, surgery or hospitalization. Also list current medications your child is taking:

Medical Insurance Name: **ID#:**_____**Group#:**_____ Primary Insured:	**Vision Insurance Name:** **ID#:** _____ **Group#:** _____ Primary Insured:

Referred by (circle): Family Friend Doctor Newspaper Coupon Facebook Walk-in Other_____
If personally referred, whom may we thank for the referral: _____

Main Reason for Today's Visit: □ Annual Exam □ Glasses □ Contacts □ Medical Visit □ Other

Primary Care Physician:
Name & Phone #

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-mydriatic 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

Medical History

WELCOME TO OUR OFFICE

We will be happy to help you fill out this form, ask for assistance.

Name: _____ Date: _____

List ALL major injuries, surgeries, and/or hospitalizations you have had:

_____

Are you pregnant and or nursing? □No □Yes

Family History

Please note any family history (parents, grandparents, siblings, children) living or deceased for the following conditions:

	No	Yourself	Relative		No	Yourself	Relative
Blindness	□	□	□_____	Diabetes	□	□	□_____
Cataract	□	□	□_____	Heart Disease	□	□	□_____
Crossed Eyes	□	□	□_____	High Blood Pressure	□	□	□_____
Glaucoma	□	□	□_____	Kidney Disease	□	□	□_____
Macular Degeneration	□	□	□_____	Lupus	□	□	□_____
Retinal Detachment	□	□	□_____	Thyroid Disease	□	□	□_____
Arthritis	□	□	□_____	Other_____	□	□	□_____
Cancer	□	□	□_____				

Please list the current medications you take (*if you have a list with you please provide us the list to make a copy*):

_____
_____
_____
_____

Please list all medical allergies and reactions (*if you have a list with you please provide us the list to make a copy*):

_____
_____
_____
_____

Social History

This information is kept strictly confidential. However you may discuss this portion directly with the doctor if you prefer.

□ Yes, I would prefer to discuss my Social History information directly with my doctor. (Check box)

Do you drive? □ No □ Yes

(If yes, do you have difficulty when driving?) □ No □ Yes (If yes describe)

_____

Do you smoke cigarettes? □ No □ Yes (If yes, type/amount/how long?) _____

Do you drink alcohol? □ No □ Yes (If yes, type/amount/how long?) _____

Do you use illegal drugs? □ No □ Yes (If yes, type/amount/how long?) _____

Have you ever been exposed to or infected with: □ Gonorrhea □ Hepatitis □ HIV □ Syphilis

****Please turn over and complete back side****

Review of Systems

Do you currently, or have you ever had any problems in the following areas?

	No	Yes
Constitutional		
Fever, Weight Loss/Gain	☐	☐
Integumentary (Skin)	☐	☐
Neurological		
Headaches	☐	☐
Migraines	☐	☐
Seizures	☐	☐
Eyes		
Loss of Vision	☐	☐
Blurred Vision	☐	☐
Distorted Vision/Halos	☐	☐
Loss of Side Vision	☐	☐
Double Vision	☐	☐
Dryness	☐	☐
Mucous Discharge	☐	☐
Redness	☐	☐
Sandy/Gritty Feeling	☐	☐
Itching	☐	☐
Burning	☐	☐
Foreign Body Sensation	☐	☐
Excess Tearing/Watering	☐	☐
Glare/Light Sensitivity	☐	☐
Eye Pain/Soreness	☐	☐
Chronic Eye Infection	☐	☐
Sties/Chalazion	☐	☐
Flashes/Floaters in Vision	☐	☐
Tired Eyes	☐	☐
Endocrine		
Thyroid/Other Glands	☐	☐

	No	Yes
Ears, Nose, Mouth, Throat		
Allergies/Hay Fever	☐	☐
Sinus Congestion	☐	☐
Runny Nose	☐	☐
Post Nasal Drip	☐	☐
Chronic Cough	☐	☐
Dry Throat/Mouth	☐	☐
Respiratory		
Asthma	☐	☐
Chronic Bronchitis	☐	☐
Emphysema	☐	☐
Vascular/Cardiovascular		
Diabetes	☐	☐
Heart Pain	☐	☐
High Blood Pressure	☐	☐
Vascular Disease	☐	☐
Gastrointestinal		
Diarrhea	☐	☐
Constipation	☐	☐
Genitourinary		
Genitals/Kidney/Bladder	☐	☐
Bones/Joints/Muscles		
Rheumatoid Arthritis	☐	☐
Muscle Pain	☐	☐
Joint Pain	☐	☐
Lymphatic/Hematologic		
Anemia	☐	☐
Bleeding Problems	☐	☐
Allergic/Immunologic	☐	☐
Psychiatric	☐	☐

If you answered YES to any of the above or have a condition not listed, please explain:

_____

_____

_____

_____

_____ _____

Doctor's Signature Date