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

If returning patient is a minor:

Parent Guardian names:_____ **Relationship:**_____

Contact #s:_____

***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