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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: <input type="checkbox"/> Male <input type="checkbox"/> Female				Social Security #: ____/____/____							
Birthdate: ____/____/____				Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed							
Cell Phone #:			Home Phone #:			Work Phone #:			Other Phone #:		
Preferred Daytime Contact: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work <input type="checkbox"/> Email <input type="checkbox"/> Text Message											
EMAIL ADDRESS:											
Occupation & Employer/ School & grade:				Employment Status: <input type="checkbox"/> Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired <input type="checkbox"/> Student <input type="checkbox"/> Disabled							
PARENT/GUARDIAN Information (if minor): Please tell us your relationship to the patient? <input type="checkbox"/> Parent <input type="checkbox"/> Grandparent <input type="checkbox"/> Other: _____ Has the child ever been prescribed glasses or contacts in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No Does the child wear glasses or contacts now? <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> Annual Exam <input type="checkbox"/> Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Medical Visit <input type="checkbox"/> 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-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

# 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Retinal Detachment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____				

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		No	Yes
<b>Constitutional</b>			<b>Ears, Nose, Mouth, Throat</b>		
Fever, Weight Loss/Gain	<input type="checkbox"/>	<input type="checkbox"/>	Allergies/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>
<b>Integumentary (Skin)</b>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>
<b>Neurological</b>			Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Post Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Dry Throat/Mouth	<input type="checkbox"/>	<input type="checkbox"/>
<b>Eyes</b>			<b>Respiratory</b>		
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Distorted Vision/Halos	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>	<b>Vascular/Cardiovascular</b>		
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	Heart Pain	<input type="checkbox"/>	<input type="checkbox"/>
Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Redness	<input type="checkbox"/>	<input type="checkbox"/>	Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>
Sandy/Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>	<b>Gastrointestinal</b>		
Itching	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Burning	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>	<b>Genitourinary</b>		
Excess Tearing/Watering	<input type="checkbox"/>	<input type="checkbox"/>	Genitals/Kidney/Bladder	<input type="checkbox"/>	<input type="checkbox"/>
Glare/Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<b>Bones/Joints/Muscles</b>		
Eye Pain/Soreness	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Eye Infection	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>
Sties/Chalazion	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>
Flashes/Floaters in Vision	<input type="checkbox"/>	<input type="checkbox"/>	<b>Lymphatic/Hematologic</b>		
Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
<b>Endocrine</b>			Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid/Other Glands	<input type="checkbox"/>	<input type="checkbox"/>	<b>Allergic/Immunologic</b>	<input type="checkbox"/>	<input type="checkbox"/>
			<b>Psychiatric</b>	<input type="checkbox"/>	<input type="checkbox"/>

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

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\_\_\_\_\_  
 Doctor's Signature

\_\_\_\_\_  
 Date