

Welcome to Eye Deal Optical

Date: _____ Name: _____

D.O.B.: _____ Occupation: _____

Email Address _____

Address: _____

City, State, Zip Code: _____

Phone: (Home) _____ (Cell) _____ (Work) _____

Marital Status: Married _____ Single _____ Widow _____ Minor (under 18yrs. Old) _____

Reason for visit: Glasses _____ Contact Lenses _____ Other _____

Method of payment: Cash _____ Credit/Debit Card _____ Check _____ Insurance _____ CareCredit _____

Patient Medical History

Date of Last Eye Exam: _____ Name of Doctor: _____

Name of Medical Doctor: _____ Date of Last Visit: _____

Please mark Yes or No for each condition

Burning/Watery Eyes	Yes	No	Arthritis	Yes	No
Cataracts	Yes	No	Asthma/Lung Problems	Yes	No
Crossed Eye(s)	Yes	No	Cancer	Yes	No
Double Vision	Yes	No	Diabetes	Yes	No
Dry Eyes	Yes	No	Frequent Headaches	Yes	No
Eye Injury/Surgery	Yes	No	Heart Attack/Heart Disease	Yes	No
Floaters	Yes	No	Head Trauma	Yes	No
Glaucoma	Yes	No	Hepatitis(Type _____)	Yes	No
Itchy Eyes	Yes	No	High Blood Pressure	Yes	No
Lazy Eye	Yes	No	High Cholesterol	Yes	No
Macular Degeneration	Yes	No	Kidney Disease	Yes	No
Ocular Trauma	Yes	No	Migraine Headaches	Yes	No
Retinal Tear/Detachment	Yes	No	Stroke	Yes	No
Seasonal Allergies	Yes	No	Thyroid condition	Yes	No
AIDS/HIV	Yes	No	Tuberculosis	Yes	No
Abnormal Bleeding	Yes	No	Other:	Yes	No

Are you pregnant? Y/N

Tobacco Use? Y/N

Alcohol Use? Y/N

FAMILY HISTORY

Glaucoma	Y/N	Which Relative:	Diabetes	Y/N	Which Relative:
Cataracts	Y/N	Which Relative:	High Blood Pressure	Y/N	Which Relative:
Lazy Eyes	Y/N	Which Relative:	Macular Degeneration	Y/N	Which Relative:

Medications

Please List any medications you are currently taking (includes eye drops):

Allergies

Please list any allergies to medication or other substances:

Vision Insurance (PLEASE COMPLETE ONLY IF USING INSURANCE)

Name of Insurance Plan: _____ Name of Insured: _____

Employer: _____ Patient I.D.# or Insured SSN#: _____

Privacy Policy

Your information must be kept confidential due to laws known as HIPPA. Please sign below stating that you have read our privacy practices.

I have received and been provided with an opportunity to read over the Privacy Practices.

Signature(Guardian if Minor) _____ Date: _____

DILATION

PUPIL DILATION ALLOWS THE DOCTOR TO EXAMINE THE INTERNAL HEALTH OF YOUR EYES; IT IS RECOMMENDED. THE DROPS WILL CAUSE BLURRED NEAR VISION AND LIGHT SENSITIVITY FOR 3-4 HOURS.

“DISTANCE VISION IS USUALLY NOT AFFECTED SIGNIFICANTLY.”

This eye doctor examines the structures of the eyes, including the optic nerve, blood vessels and retina, in great detail. Dilation is a key component of a comprehensive eye examination, as it sometimes leads to the detection and diagnosis of certain eye diseases.

I UNDERSTAND THE IMPORTANCE OF PUPILLARY DILATION. I DO _____ OR DO NOT _____ GIVE MY PERMISSION FOR DIAGNOSTIC DROPS TO BE ADMINISTERED TO MY EYES.

SIGNATURE: _____ DATE: _____

Assignment and Release

I authorize my insurance company to pay directly to the eye doctor and/or supplier benefits otherwise payable to me for services rendered.

The doctor and/or supplier may use my health care information and may disclose such information to the above named insurance company for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This signature is good for one year from date signed below.

Signature of Patient, Guardian, or Parent: _____ Date: _____
