Elite Eye Care

Today's Date

Patient Information

Last Name

First Name MI

Address

City State Zip

Date of Birth Age Sex ☐M ☐F

Patient's SSN

Ethnicity: (Optional) ☐ African American

☐ American Indian ☐ Asian ☐ Hispanic/Latino

☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Other

Home Phone

Work Phone

Cell Phone May we text you ☐ Yes ☐ No

Email (Please include an email address so we can begin confirming appointments via email)

____

May we leave you voice mails ☐ Yes ☐ No

Employer

Occupation

School Name

Grade

Spouse or Parent(s) Name

Spouse or Parent(s) Work

Are you having any problems with your current eyeglasses/contact lenses? ☐ Yes ☐ No

If Yes, please explain:

____

____

____

Patient Medical History

Family Physician______________________________

Address ______________________________

Phone ______________________________

Pharmacy ______________________________

Location ______________________________

Phone ______________________________

Have you ever been diagnosed or treated for the following health problems?

☐ Fatigue Syndrome	☐ Ulcer
☐ Cancer	☐ Acid Reflux
☐ Developmental Disorder	☐ Prostate Disease
☐ Laryngitis	☐ Kidney Disease
☐ Sinusitis	☐ Muscular Dystrophy
☐ Hearing Loss	☐ Arthritis
☐ Multiple Sclerosis	☐ Fibromyalgia
☐ Stroke	☐ Eczema
☐ Epilepsy	☐ Thyroid
☐ Depression	☐ Diabetes
☐ High Blood Pressure	☐ Blood Loss
☐ Vascular Disease	☐ Ulcer
☐ Congestive Heart Failure	☐ Anemia
☐ Asthma	☐ Environmental Allergies
☐ Emphysema	☐ Rheumatoid Arthritis
☐ Bronchitis	☐ Other
☐ Latex Sensitivity	

Current Medications: (RX or over the counter) List name of medications including eye drops, vitamins & birth control

____

____

____

Allergies to Medications ☐ Yes ☐ No

If yes, what medications are you allergic to?

____

Patient Eye History

Date of Last Eye Exam_____________________________

By Whom _____________________________

Do you wear: ☐ Eyeglasses ☐ Contact Lenses

If contacts, what kind are you currently using?

____

What type of solution are you using?

____

Are you satisfied with the vision and comfort of your contact lenses?

☐ Yes ☐ No

Would you prefer clear contact lenses or colored contact lenses?

☐ Clear ☐ Colored

If eyeglasses, and are wearing bifocals, do the lines or head tilting bother you? ☐ Yes ☐ No

Have you ever experienced, been diagnosed or treated for any of the following?

☐ Eye Surgery	☐ Patching
☐ Glaucoma	☐ Glaucoma Suspect
☐ Macular Degeneration	☐ Eye Injury
☐ Lazy Eye	☐ Burning
☐ Inflammatory Disorder	☐ Floaters/Spots
☐ Retinal Degeneration	☐ Double Vision
☐ Retinal Hole	☐ Occasional Dryness
☐ Cataract	☐ Trouble Seeing at Night
☐ Sunlight/Light Sensitivity	

Family History

Is there a family medical history of any of the following?

(Check all that apply)	Please list family member:
☐ Thyroid	_______________
☐ Diabetes	_______________
☐ Heart Disease	_______________
☐ High Blood Pressure	_______________
☐ Cancer	_______________
☐ Lazy Eye	_______________
☐ Cataract	_______________
☐ Glaucoma	_______________
☐ Retinal Problems	_______________
☐ Macular Degeneration	_______________
☐ Blindness	_______________
☐ Corneal Problems	_______________

Do you use alcohol?	☐ Yes	☐ No
Do you use tobacco?	☐ Yes	☐ No
Tobacco Use:	☐ Cigars	☐ Cigarettes
	☐ Other	☐ Smokeless Tobacco

Please Check One of the Following:

☐ Dilation & Retinal Scan - $32.50: Insurance mandates that Elite Eye Care dilates all patients every two years (diabetics every year). In addition to dilation, Dr. Perry recommends documentation of retinal findings (Optomap) to analyze a complete retinal view with your comprehensive exam. Optomap is not covered by vision care insurance.

☐ Retinal Scan Only - $32.50: I decline dilation and have been educated of the risks of the Doctors inability to discover retinal tears, cancers, etc (risk of significant loss of vision). Optomap is not covered by vision care insurance.

☐ Dilation Only

_____ **(Please Initial)** I hereby acknowledge that I have been provided with a copy of the “Notice of Privacy Practices” (HIPAA Privacy Act) of Elite Eye Care OD PLLC for my own records.

I, the undersigned, certify that I (or my dependent) have insurance coverage with and assign directly to Elite Eye Care OD PLLC, all insurance benefits if any, otherwise payable to me for services rendered. I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____________________________ _______________

Signature Date