

Patient's Name					
Street Address					
City, State, Zip Code					
Home Phone Number		Cell Nu			
Email Address (will not sell/distribute	e)				
Date of Birth/		Age			
		Occupation			
Spouse's Name	Emplo	yer			
Who will be responsible for the finance	cial aspect	of this ca	se? [] Same as above.		
Person's Name					
Street Address					
City, State, Zip Code					
Bill payer's SS#/Medicare #					
Insurance Holder's Date of Birth	//				
Insurance Company Name					
How did you hear of our practice?					
Where and when was your last eye ex	am?				
What brings you in today?					
Medical History: Anxiety	YES	NO	Hearing Loss	YES	NO
Arthritis/Joint Pain Asthma Atrial Fibrillation (Irregular Heartbeat) Bone Marrow Transplant BPH Breast Cancer Colon Cancer COPD Coronary Artery Disease Depression Diabetes End Stage Renal Disease GERD			Hepatitis Hypertension HIV/AIDS Hypercholesterolemia Hyperthyroidism Hypothyroidism Leukemia Lung Cancer Lymphoma Pregnancy/Nursing Prostate Cancer Radiation Treatment Seizures Stroke		
Other (please list)	[]	[]			

SEE OTHER SIDE

Allergies: Environmental or medication	Y	ES l	N()	
Medication & dosage currently in use	ſ]	ſ	1	
Past surgeries: (please list all)					
Social History					
Are you a cigarette smoker?	ſ]	[1	How much per day?
Do you currently use recreational drugs?	[j	ĺ	ĺ	1 3
Do you drink alcohol?	[j]	j	How much per week?
Past History (Eye)					
Glasses or Contacts	ſ	1	[1	
Dry Eyes	j	j	į	j	
Itchy or irritated eyes	[]	[]	
Do you drive	[]	[]	
History of cataract	[]	[]	Right Left Both
History of glaucoma	[]	[]	
History of crossed/lazy eye	[]	[]	
Eye injury or other disease	[]	[]	·
Eye surgery	[]	[]	
Family History					
Blindness	[]	[]	
Cataract	[]	[]	
Glaucoma	[]	[]	
Macular degeneration	[]	[]	
Retinal detachments	[]	[]	
Diabetes	Į]	Į]	
High blood pressure	Į]	[]	
Cancer	Į]	Į]	
Other general health problems	L]	L]	
Pediatric History for Children under 10	Yea	ars of	f Age		
Birth Weight					
Weeks Gestation	_				
Reached Developmental Milestor	ies?		[] ye	es [] no
Insurance Assignment, Release and Not	ice o	f pri	vacy	pra	actices.
	l. I u	nders	tand t	hat I	assign them directly to Advanced Eyecare Clinic, am financially responsible for all charges whether insurance submissions.
I authorize Advanced Eyecare Clinic, Inc to rel treatment or examination, of me or my depende practitioners. I acknowledge that I have been of opportunity to review it. The information provi	ents, fere	durin d the	g the p Notice	eric	od of care to third party payers and/or health Privacy Practices and have been provided an
Signature					Date

Advanced Eyecare Clinic, Inc. Dilation of the Pupils

One of the most important tests that your doctor does as part of a regular eye exam is to look inside of your eyes. Many health problems of both the eyes can often be detected this way.

Much more of the inside of your eyes can be examined if special eye drops are used to temporarily dilate (enlarge) your pupils (the center black part of your eye). The doctor will put eye drops into your eyes, and then about 20 to 30 minutes later (most patients choose to pick out glasses during this time), he/she will examine the back of your eye. Unfortunately, the dilation will increase your sensitivity to bright light for about 4 to 6 hours. We can provide disposable sunglasses for this time. The drops will also probably decrease your close vision for 2 to 3 hours. Keep in mind, driving or returning to work or school may be difficult during this time.

The doctor recommends that all patients have their eyes dilated to examine for diseases and disorders that may lead to future vision problems or even blindness. The following groups of people are in the greatest need of regular dilated examinations:

- New Patients
- Diabetic patients
- Patients with High Blood Pressure
- Anyone 50 years of age and older

Date _____

- People with a family history of eye disease or blindness
- Nearsighted people with a strong prescription
- Anyone experiencing unexplained flashes of light and/or an increase in floaters in their eyes

Please indicate below if you would like to have your eyes dilated. If you have any

questions, please feel free to speak to the doctor. Thank you.

Yes, Today if possible

Yes, I can't today, but I will set up an appointment

No, I prefer not to be dilated

Patient Name:

Patient Signature

(Parent or guardian's signature if patient is a minor)