Eyes & Optics, P.L.
312 N. Park Ave.
Winter Park, FL 32789
407.644.5156 www.eyesoptics.com

Welcome!

Name:______________________________ Date:______________

Address:______________________________ City:______________

State:________ Zip:______________ E-Mail:______________________

Home:(____)______________ Work:(____)______________ Cell:(____)______________

Birth Date:__________ Sex: M F Employer:______________ Occupation:______________

Vision & medical insurance:______________ Primary Insured Name & DOB:

Emergency contact:______________________________ Ph: (____)______________

Primary Care Provider:______________________________ Ph: (____)______________

What hobbies do you enjoy?____

How did you hear about our office? Referral Ad Walk-by Internet Insurance Other

Do you wear contacts? Y N Type: Soft Hard Solution:______________

Do you have eyestrain from computers? Y N Do you own prescription sunglasses? Y N

Medical Questionnaire:

Do you have any of the following?		Family Member?/Relation	
Y N	High Blood Pressure	Y N	______________
Y N	Heart Disease	Y N	______________
Y N	Diabetes (Since:_______)	Y N	______________
Y N	Thyroid Problems	Y N	______________
Y N	Headaches/Migraines	Y N	______________
Y N	Arthritis	Y N	______________
Y N	Pulmonary Disease	Y N	______________
Y N	High Cholesterol	Y N	______________
Y N	Cancer	Y N	______________
Y N	HIV or Hepatitis	Y N	______________
Y N	Glaucoma	Y N	______________
Y N	Cataracts	Y N	______________
Y N	Macular Degeneration	Y N	______________
Y N	Retinal Detachment	Y N	______________
Y N	Eye Surgery	Y N	______________
Y N	Vision Loss/Blindness	Y N	______________
Y N	Visual Spots		
Y N	Flashing Lights		
Y N	Other______________		
Y N	Are you pregnant?		
Y N	Are you nursing?		

List any eye surgeries:

____
____
____
____

List Your Medications:

____
____
____
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____
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____

List Your Allergies:

____
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____
____
____

Social History:

Tobacco?	Y N
Alcohol?	Y N
Drugs use?	Y N

Reason for Visit:____

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Pupillary Dilation

Florida law requires all Board Certified Optometric Physicians to include pupillary dilation as a part of a **NEW** Comprehensive Eye Exam. After the dilated examination, you may experience blurred vision and light sensitivity for approximately four (4) to six (6) hours. This could possibly impact your ability to drive or perform certain visual tasks. Pupillary dilation is an important component of an eye exam because it enables the physician to better evaluate the health inside your eyes. Without it, it is possible to overlook potential vision or life-threatening conditions. Please check which option below best suits your schedule:

______I would like to have my eyes dilated today.

______I would like to reschedule the dilated portion of my exam to another day.

______I do not want my eyes dilated.

Signature:____Date:____________________

Printed Name:____

Visual Field Testing

Unfortunately, routine eye exams alone cannot detect many problems such as glaucoma, retinal disease, multiple sclerosis, or brain tumors in their early stages. We are now offering visual field screenings for all patients receiving a comprehensive eye exam. The purpose of the visual field is to test your vision for any unusual blind spots. Most of the time patients are unaware of these problems. Our state-of-the-art ***Humphrey Matrix Visual Field Analyzer*** is an excellent screening tool that helps to rule-out serious eye disease or neurological problems. The screening itself takes just a few minutes to complete and only costs $15.00.

______I would like to have the screening ($15.00).

______I do not want the screening.

Signature:____Date:____________________

Printed Name:____

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LIFETIME PATIENT CONSENT FORM

I understand that under ***The Health Insurance Portability & Accountability Act of 1996*** (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment, directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your **NOTICE OF PRIVACY PRACTICES** containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such **NOTICE OF PRIVACY PRACTICES** from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the **NOTICE OF PRIVACY PRACTICES.**

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent. This form is valid until your personal revocation.

Please list family/friends that may have access to your medical information below:

Name: ______________________ Relation: ______________ Phone #: ______________

Name: ______________________ Relation: ______________ Phone #: ______________

Name: ______________________ Relation: ______________ Phone #: ______________

Patient Name: ____

Signature: ______________________________ Date: ______________

Relation to Patient (if minor): ______________________________