Date:_____ Date:_____ Date:_____ Date:_____

Patient's Name:_____ Patient's D.O.B:_____

Patient's Address:_____ Age:_____

City:_____ State:_____ Zip Code:_____

Patient Phone:_____ Email:_____

Occupation:_____ How Many Hours are you on the computer/phone/tablet per day?_____

Date of the last Exam:_____ How did you hear about us?_____

Has the patient ever worn glasses? YES_____ NO_____ Contact Lenses? YES_____ NO_____

Do you want a prescription for CONTACT LENSES today? YES_____ NO_____ Clear _____ Color _____

Patient

Reason for visit:_____
Lost or broken Glasses/Want New Glasses
Blurred Distance/Near Vision
Are you pregnant or Nursing? YES____ NO____

Family History

___ Glaucoma
___ Cancer
___ Diabetes
___ Macular Degeneration
___ Retinal Disorder
___ High Blood Pressure
___ Thyroid
___ Heart Disease/Stoke

Medication the patient is taking (i.e. Oral contraceptives, aspirin, over the counter, home remedies):

_____

List anything the patient is allergic to:_____

List any major eye injuries or eye surgeries the patient has had:_____

I am aware the Doctor may use dilating drops: Consent_____ Decline _____ Signature:_____

All Insurance patients: I am aware that I am responsible for any examination fee not covered by my insurance and I acknowledge that I have been offered a copy of the privacy notice and I authorize Family Optometric Associates to release my medical record to my insurance company.

Patient Signature(Parent if patient is minor):_____ Date:_____

******VISION INSURANCE SECTIO: PLEASE FILL OUT THIS SECTION******

Vision Insurance Company:_____ Medical Insurance Company Name:_____

Insurance ID# or Policy Holder SS#:_____ Medical ID#_____

Policy Holder/Sponsor Name:_____ D.O.B_____

Policy Holder Address if different from patient:_____

Policy Holders Employer:_____

******FOR STAFF ONY******

DOS:_____Verifier:_____ Tech:_____ Copay/CL Fit:_____ Photos:_____ Dx:_____

DOS:_____Verifier:_____ Tech:_____ Copay/CL Fit:_____ Photos:_____ Dx:_____

DOS:_____Verifier:_____ Tech:_____ Copay/CL Fit:_____ Photos:_____ Dx:_____

DOS:_____Verifier:_____ Tech:_____ Copay/CL Fit:_____ Photos:_____ Dx:_____

Retinal Photography

At Family Optometric Associates, we pride ourselves in providing our patients with the best possible standard of eye-care. Retinal photography is a non invasive test that provides our doctors with a photo of your retina. This image becomes a permanent part of your medical file, allowing our doctors to make important comparisons year to year.

These images will help see early signs of many ocular and systemic diseases which can lead to partial or total loss of vision. Some condition often develop without warning and progress with no symptoms.

These conditions include, but are not limited to:

- Glaucoma
- Macular Degeneration
- Diabetes
- High Cholesterol
- Retinal Holes or Detachment

This Photography is an essential part of your eye exam.

THERE IS AN ADDITIONAL FEE OF $39.00 FOR THIS ADVANCED TEST.

☐ **YES, I would like** to have retinal photography done.

☐ **NO, I would NOT like** to have retinal photography done.

_____

Patient Name

_____ _____

Printed Name Signature Date