ADVANCED EYECARE

PATIENT REGISTRATION & MEDICAL HISTORY FORM

Print & Complete Papework. Do NOT email paperwork.

First Name: _____ Last Name: _____ Middle Initial: _____ Preferred Name: _____

Birth Date: _____ Social Security Number: _____ Sex: M / F

Home Address: _____ Zip: _____ City: _____ State: _____

Which phone number would you prefer we use to contact you? ☐ Home ☐ Work ☐ Cell Home Phone: _____

Cell Phone: _____ Work Phone: _____ E-mail address: _____

Marital Status: ☐ Single ☐ Married ☐ Other Referred by: _____ ***We must have a copy of all insurance cards on the day of service***

Provide Insurance Names & Member IDS Below

Primary Medical Insurance: _____ Secondary Medical Insurance: _____

Vision Insurance: _____ Primary Insured's Name: _____ Insured's D.O.B: _____

Insured's Birth Date: _____ Insured's Employer: _____ Insured's SSN: _____

Family Doctor: _____ Family Dr. Clinic/Phone: _____

Family Members: _____ For ease of data transfer, are they patients at this office? Y / N

How did you hear about us? ☐ Friend/Family ☐ Insurance ☐ Social Media ☐ Website ☐ Other: _____

NOTICE OF PRIVACY PRACTICES: I/We have been offered a copy of Advanced Eyecare's statement on privacy practices
AUTHORIZATION TO RELEASE INFORMATION: I/We hereby authorize Advanced Eyecare to release any medical or incidental information that may be necessary for medical benefit of in processing applications for financial benefit. This includes but is not limited to my insurance company, Rehabilitation Services, Social Security Administration, and Worker's Compensation.
CONSENT FOR TREATMENT: I/We hereby authorize Advanced Eyecare to administer diagnostic and medical procedures as may be necessary for proper health care.
OFFICE POLICY ON PAYMENT: I understand that I am responsible for payment of all charges. As a courtesy, my insurance will be billed for me. It is my responsibility to pay any deductible, copay or any other balance not paid by my insurance company. I authorize insurance benefits to be paid directly to the provider.
VISION PLAN COVERAGE: I/We understand that only one vision plan may be used for exam/materials per visit-per patient and that the vision plan to be used must be chosen before the exam occurs and can not change at a later date

SIGNATURE: _____ DATE: _____

REASON FOR VISIT

How can we help you today? In the space below please explain any signs and/or symptoms that you are experiencing. **Medical Insurance will only cover if there is a medical reason for the exam** such as loss of vision, headaches, eye pain, eye itching or burning, redness, glaucoma, cataracts, dry eye, floaters, etc.

_____

_____

_____

FAMILY HISTORY

Has anyone in your family been diagnosed with any of the following (check all that apply):

☐ No problems ☐ Diabetes ☐ High blood pressure ☐ Cancer

Has anyone in your family been diagnosed with any of the following eye problems (check all that apply):

☐ No problems ☐ Glaucoma ☐ Amblyopia ☐ Cataracts ☐ Macular degeneration ☐ Strabismus (eye turn)

Other:

SOCIAL HISTORY

Do you smoke? ☐ Y ☐ N

If yes, what do you smoke? ☐ Cigarettes ☐ Cigars ☐ Pipes

How much per month do you smoke? _____

Do you consume alcohol? ☐ Y ☐ N

If yes, how much do you drink? _____

What is your occupation? _____

CURRENT VISION

Glasses: Do you currently wear glasses? ☐Y ☐N *if yes, answer the questions below; if no, continue to contact lenses section:*
What type of lenses are in your glasses? ☐ **Single vision** ☐ **Bifocal** ☐ **Trifocal** ☐ **No-line (Progressive)**

Contact Lenses: Are you interested in contact lenses today? ☐Y ☐N
Do you currently wear contact lenses? ☐Y ☐N *if yes, answer the questions below; if no, continue to past ocular history section:*
What type of contact lenses do you wear? ☐ **Soft** ☐ **Rigid**
What is the manufacturer/model of your contact lenses? _____
What are the powers of your contact lenses (if you know)? _____
How old are your current contact lenses? _____ **Months / Years**
How often do you replace your contact lenses? ☐ **Daily** ☐ **Weekly** ☐ **2 weeks** ☐ **Monthly** ☐ **3 months** ☐ **6 months** ☐ **Annually**
What solutions do you use to care for contact lenses? ☐ **Renu** ☐ **Optifree** ☐ **Clear Care** ☐ **Boston Advance** ☐ **Boston Simplus** ☐ **Biotrue** ☐ Other: _____

REVIEW OF SYSTEMS

Ocular/Eye Problems
- Inflammatory disorder ☐Y ☐N
- Surgery ☐Y ☐N
- Glaucoma ☐Y ☐N
- Amblyopia (lazy eye) ☐Y ☐N
- Cataract ☐Y ☐N
- Retinal problems ☐Y ☐N
- Macular degeneration ☐Y ☐N
- Strabismus (eye turn) ☐Y ☐N
- Amblyopia (lazy eye) ☐Y ☐N
- Other _____

Constitutional Problems
- Cancer ☐Y ☐N
- Fatigue ☐Y ☐N
- Developmental disability ☐Y ☐N
- Other _____

Ears, Nose, Mouth, Throat Problems
- Laryngitis ☐Y ☐N
- Dry mouth ☐Y ☐N
- Hearing loss ☐Y ☐N
- Sinusitis ☐Y ☐N
- Other _____

Neurological Problems
- Cerebral palsy ☐Y ☐N
- Multiple sclerosis ☐Y ☐N
- Tumor ☐Y ☐N
- Epilepsy ☐Y ☐N
- Other _____

Psychiatric Problems
- Depression ☐Y ☐N
- Other _____

Cardiovascular Problems
- Vascular disease ☐Y ☐N
- Stroke ☐Y ☐N
- Congestive heart failure ☐Y ☐N
- Heart disease ☐Y ☐N
- High blood pressure ☐Y ☐N
- Other _____

Respiratory Problems
- Emphysema ☐Y ☐N
- Bronchitis ☐Y ☐N
- Smoker ☐Y ☐N
- COPD ☐Y ☐N
- Asthma ☐Y ☐N
- Other _____

Gastrointestinal Problems
- Colitis ☐Y ☐N
- Chron's disease ☐Y ☐N
- Ulcer ☐Y ☐N
- Other _____

Genitourinary Problems
- Prostate disease/cancer ☐Y ☐N
- STD ☐Y ☐N
- Kidney disease ☐Y ☐N
- Other _____

Musculoskelatal Problems
- Ankylosis spondylitis ☐Y ☐N
- Fibromyalgia ☐Y ☐N
- Muscular dystrophy ☐Y ☐N
- Osteoarthritis ☐Y ☐N
- Other _____

Skin Problems
- Rosacea ☐Y ☐N
- Psoriasis ☐Y ☐N
- Eczema ☐Y ☐N
- Other _____

Endocrine Problems
- Insulin dependent diabetes ☐Y ☐N
- Hormonal dysfunction ☐Y ☐N
- Thyroid dysfunction ☐Y ☐N
- Non-insulin diabetes ☐Y ☐N
- Other _____

Blood/Lymph Problems
- Large volume blood loss ☐Y ☐N
- Anemia ☐Y ☐N
- Other _____

Allergy/Immunologic Problems
- Environmental allergies ☐Y ☐N
- Rheumatoid arthritis ☐Y ☐N
- Drug allergies ☐Y ☐N
- Lupus ☐Y ☐N
- Other _____

Are you pregnant or nursing? ☐Y ☐N

Pharmacy Information

Pharmacy Name: _____

Pharmacy Address: _____

_____

Pharmacy Telephone #: _____

Do you sometimes experience dry eyes? ☐Y ☐N

Are your eyes sensitive to sunlight? ☐Y ☐N

Do you work at a computer ? ☐Y ☐N

Problems with reflections and/or glare? ☐Y ☐N

Prefer not to wear your glasses at times? ☐Y ☐N

Interested in newer contact lens technology? ☐Y ☐N

Want information on thinner / lighter lenses? ☐Y ☐N

Want information on LASIK vision surgery? ☐Y ☐N

Want a non-surgical option to LASIK? ☐Y ☐N

Do you have any children? ☐Y ☐N

Do you spend time outdoors? ☐Y ☐N

Please list your sporting activities / hobbies:

_____

List any medications you are currently taking: Fill out BELOW or provide us with a list to copy at Check-In

_____

_____

_____

_____

_____

List any medicine allergies:

_____

List any other allergies:

_____

OPTOS/ or Dilation Consent

As part of today's services, Dr. Nelms will need to evaluate the internal health of your eyes. This part of the eye health evaluation allows Dr. Nelms to detect potential retinal conditions that may include holes, detachments, degenerations, and glaucoma. This part of the examination may detect systemic conditions such as diabetes and hypertension which may be undetected.

➡ **Please select the option on how you would like your internal eye health examination performed.**

_____ YES, I WANT OPTOS ULTRA-WIDEFIELD IMAGING

- Specialized camera to take digital images inside the eye
- Dr. Nelms will review images with you, and will have images saved for future comparison
- This equipment allows 15 minutes to be cut off your exam time
- This equipment does not cause light sensitivity or blurred vision
- OPTOS fee is $39 [most insurances will not cover this cost]

OR

_____ YES, I WANT PUPIL DILATION

- Ophthalmic drops that will create light sensitivity and up-close blurred vision
- Side effects can last about 4-6 hours
- Drops will add 15 minutes to your exam
- Dilation is no extra charge

_____ _____

Patient/ Guardian Signature Date