Welcome to Spectacle! In order to provide you with the best care possible, please answer the questions below. If you prefer, just ask and our staff will be happy to sit down with you to help you complete this form.

PATIENT INFORMATION

Last Name:_____ First Name:_____ MI:_____ Date:_____

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

Phone: cell (_____)_____ Home: (_____)_____ Email:_____

Date of Birth: _____ Age: _____ Gender: M / F Occupation: _____

Emergency Contact: _____ Phone _____

PATIENT EYE & MEDICAL HEALTH HISTORY

Date of last eye exam:_____ By whom?_____

Do you wear glasses? □ Yes □ No How old are your glasses? _____ Interested in contact lenses? □ Yes □ No

Do you wear contacts? □ Yes □ No If yes, type/brand:_____ Do you sleep in your contacts? □ Yes □ No

Please check if you have/had any of the following:

□ eye injury □ retinal detachment □ glaucoma □ cataracts □ lazy eye □ eye turn □ dry eyes □ macular degeneration □eye surgery (describe)_____

Check all that apply:

□ blurred distance vision □ blurred near vision □ double vision □ red eyes □ itchy eyes □ unusual discharge □ stinging/burning □ flashes □ floaters □ eyestrain/eye fatigue □other_____

Have you ever been diagnosed with: □ diabetes □ high blood pressure □ arthritis □ thyroid □ heart problems □ other _____

Are you currently taking medication? □yes □no Please list:_____

_____

Do you have any allergies? □yes □no Please list:_____

FAMILY EYE & MEDICAL HISTORY

Please check any conditions that have occurred in your immediate family:

Disease/Condition	No	Yes	?	Relation	Condition	No	Yes	?	Relation
Blindness	□	□	□	_____	Diabetes	□	□	□	_____
Cataract	□	□	□	_____	Heart Disease	□	□	□	_____
Glaucoma	□	□	□	_____	Cancer	□	□	□	_____
Macular Degeneration	□	□	□	_____	Thyroid	□	□	□	_____
High Blood Pressure	□	□	□	_____	Arthritis	□	□	□	_____
Retinal Disease	□	□	□	_____	Other _____				

REVIEW OF SYSTEMS

Have you had any ongoing problems with any of the following systems? Please check all that apply:

□ gastrointestinal	□ nervous system	□ endocrine/glands	□ ear/nose/throat
□ urinary tract	□ blood/lymph	□ muscles/bones	□ respiratory
□ cardiovascular/heart disease	□ integument/skin	□ allergic/immunologic	□ headaches
□ high blood pressure	□ cancer	□ psychiatric/psychological	□ diabetes

Please explain:_____

_____

Other health problems: _____

INSURANCE INFORMATION

Vision Insurance _____ Primary Policyholder_____

Policyholder ID#_____ DOB:_____ SS#_____

I authorize the doctor to bill my insurance carrier on my behalf. I request that payment of authorized insurance benefits be made to the doctor for any services furnished me by this office. I understand that I am financially responsible for any balance not covered by my insurance carrier, and that a quotation of benefits is not a guarantee of coverage.

Patient/Guardian Signature:_____ Date:_____

DILATION

The dilation of the pupils is recommended for all ages. It is especially important for those who have glaucoma, cataracts, retinal problems, macular degeneration, diabetes and high blood pressure. Your near vision will be blurred and you will be extremely light sensitive for 4-6 hours. We recommend that you have someone drive you home afterwards, but in many cases patients are able to drive home safely themselves. Occasionally the doctor may recommend dilation in order to obtain a more accurate prescription.

The fee for dilation is $25.

Please check accept/decline: **Dilation**: □Accept □Decline

Patient/Guardian Signature:_____ Date:_____

NOTICE OF PRIVACY PRACTICES & OFFICE POLICIES

Our Notice of Privacy Practices and Office Policies are available at the reception desk. The Privacy Practice Notice describes in greater detail how your health information may be used or disclosed, and how you can access your information. You are entitled to a copy of this Notice as well as our Office Policy Notice and copies are available at your request.

I have reviewed a copy of the HIPAA Notice of Privacy Practices and Spectacle's Office Policies.

Patient/Guardian Signature:_____ Date:_____

AUTHORIZATION

I certify that the given information is correct to the best of my knowledge. I authorize the doctor to release any information including the diagnosis and records of any treatment or examination rendered to me or my child to 3rd party payers and practitioners. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for the payment of all services rendered on my behalf or my dependents. Service charges of 5% per month will be added on all balances over 60 days past due. In the event it becomes necessary to collect fees through litigation, the patient agrees to pay all collection fees, court costs, deposition fees and reasonable attorney's fees incurred.

Patient/Guardian Signature: _____ Date:_____