

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:

<b>Disease/Condition</b>	<b>No</b>	<b>Yes</b>	<b>?</b>	<b>Relation</b>	<b>Condition</b>	<b>No</b>	<b>Yes</b>	<b>?</b>	<b>Relation</b>
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Other _____				

**REVIEW OF SYSTEMS**

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

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