**WELCOME TO PRECISE EYECARE**

Last Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alternate Phone (work/mobile) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age\_\_\_\_\_\_ Sex \_\_\_\_\_\_\_Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Vision Insurance \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Insured Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Social Security \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: (*use for appointment confirmations and reminders*) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about us? direct mail/flyer internet newspaper drive by other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

friend/family referral -- whom may we thank for the referral? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_+\_p to Insured \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ \_

Date of last eye exam \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Location /Doctor (if known) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you currently wear glasses? □ Yes □ No

Have you ever worn contact lenses? □ Yes □ No If Yes, what type/brand\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for your visit today: □ Eye examination □ Contacts

□ Glasses □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you experience vision problems at: □ distance □ near □ intermediate range

Do **you** or anyone in your **immediate family** have a history of the following:

High Blood Pressure □ Self □ Family

Diabetes □ Self □ Family

Heart condition □ Self □ Family

Thyroid □ Self □ Family  
High Cholesterol □ Self □ Family

Currently Pregnant □ Yes

Glaucoma □ Self □ Family

Cataract(s) □ Self □ Family

Eye Injury/surgery □ Self □ Family

Eye disease □ Self □ Family

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Self □ Family

List any medications you are taking: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any allergies you have: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**We are committed to early detection and prevention of eye diseases. We strongly recommend that all of our patients have their eyes DILATED as part of their comprehensive vision examination.**

A **dilated fundus exam** helps us detect diseases within the eye that may not be visible during a basic eye exam and is strongly encouraged if the patient has diabetes, high blood pressure, high prescription, or a family history of eye diseases. The side effects are blurred near vision and light sensitivity for a few hours. In some individuals, distance vision may also be affected. The additional fee for this test is **$15** and is covered by most insurance plans. Please select one:

□ I **DO** want the dilated fundus exam. □ I do **NOT** want the dilated fundus exam.

**ALL FEES FOR PROFESSIONAL SERVICES ARE NON-REFUNDABLE AND PAYABLE AT TIME OF SERVICE.**

I authorize the release of any medical information necessary that will be beneficial to my eye examination. I also authorize payment of medical benefits to my doctor and understand that I am responsible for any charges not covered by my insurance. I have also been presented with the notice of privacy from Precise Eyecare.

**Signature**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to patient (if patient is a minor) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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