

Welcome To Primary Eyecare!

LAST NAME	FIRST NAME & MIDDLE INITIAL	WHAT NAME WOULD YOU LIKE OUR STAFF TO CALL YOU?	DATE
ADDRESS	CITY	STATE & ZIP	E-MAIL ADDRESS <small>*This information is kept private</small>
PLACE OF EMPLOYMENT(or SCHOOL)	TYPE OF WORK (or GRADE)	DATE OF BIRTH & AGE	SOCIAL SECURITY NUMBER
IF MINOR, PARENT NAME	CELL PHONE <small>Can you receive text messages? Y N</small>	HOME TELEPHONE	WORK TELEPHONE <small>May we contact you at work? Y N</small>

What is the major purpose of today's visit?

VERY IMPORTANT! NEW PATIENTS ONLY:

Whom may we thank for referring you to our office?

Name of friend or relative: _____

If not referred, how did you choose our office for your needs?

- Saw sign / building Yellow Pages
 Insurance List Another Dr. _____
 Newspaper / Radio / TV
 Web Pages: Which web site? _____
 Other: _____

INSURANCE INFORMATION

Vision Insurance _____

Subscriber Name _____

Subscriber ID# _____

Subscriber Birth Date _____

Primary Medical Insurance _____

Subscriber Name _____

Subscriber ID# _____

Subscriber Birth Date _____

Do you participate in a flex spending account? Yes No

How will you settle your account today? cash check credit

PATIENT MEDICAL HISTORY

Name of Family Physician _____

CURRENT MEDICATIONS (Rx or Over the Counter)
 (Please list names of medications including eye drops, vitamins, & birth control pills)

Allergies to Medications : No Yes- Which?

Have you ever been diagnosed or treated for the following?

- | | | |
|-----------|-------------------|--------------|
| Allergies | Diabetes | Thyroid |
| Asthma | Heart Disease | Other: _____ |
| Arthritis | High Blood Press. | Cancer |
| Kidney | Cholesterol | Nerves |

PATIENT EYE HISTORY

Date of Last Eye Exam _____

By Whom? _____

Do you currently wear contact lenses? Yes No

What kind? _____

Have you ever worn contact lenses? Yes No

Are you interested in contact lenses today? Yes No

Would you prefer clear contact lenses, or colored contact lenses to change the color of your eyes? _____

Do you.....(Check if your answer is Yes)

Work at a computer? (How much) _____ hrs/week

Spend time outdoors? (How much) _____ hrs/week

Want information on Laser Vision Correction Surgery?

Have you ever been diagnosed or treated for the following?

- | | | |
|------------------|----------------|----------------------|
| Cataracts | Eye Surgery | Macular Degeneration |
| Corneal Abrasion | Glaucoma | Retinal Detachment |
| Eye Infection | Iritis/Uveitis | Other Eye Disorders |
| Eye Injury | Lazy Eye | |

Do you experience or have you ever experienced?

Blurry Vision Floaters / spots

Burning Grittiness

Tearing Itchiness

Headaches Crossed eye / eye turn

Double Vision Trouble seeing at night

Flash of Light Bothered by Glare

EMERGENCY CONTACT

Name: _____

Relationship: _____

Daytime Telephone: _____

Cell Phone: _____

***Please see reverse side ----->



Payment is Due at Time Services Are Rendered

**Authorization to Pay Medical & Optical Benefits
Directly to the Attending Physician**

For those patients with specific vision insurance for which we are providers (VSP, DavisVision, Anthem, etc): I hereby authorize my insurance carrier (both primary and secondary carriers) to make payments directly to Primary Eyecare for all medical and optical expense benefits otherwise payable to me for this period of treatment. I also authorize the release of medical records by Primary Eyecare. I understand that I am financially responsible to Primary Eyecare for any and all charges not covered by my insurance benefits.

Contact Lens Medical Management

For your health and safety, we perform annual contact lens evaluations. A separate contact lens fee (starting at \$51.00) is charged beyond the comprehensive eye examination. Your doctor determines the fit, health and condition of the eyes with contact lenses. We also evaluate changes in prescription and lens design during this process.

Warning about Eye Dilation

As part of the eye examination, it may be necessary to dilate the pupils of the eye. This may hinder your ability to safely drive and your work may be impaired for up to four or five hours by blurred vision, glare, or light sensitivity. If you do not want your eyes to be dilated, please discuss this with the staff.

Delinquent Accounts

I hereby authorize any necessary medical treatment by the optometrists in the practice of Primary Eyecare, Drs. DiGirolamo & Associates, Optometrists and agree to be responsible for my bill and any reasonable collection fees incurred by Primary Eyecare to collect payment of materials and/or services rendered. I authorize the office of Primary Eyecare to release or obtain any required medical information from my attending physicians or medical facility.

Warning about Pregnancy

If you are pregnant or think you might be, please notify the staff and doctor prior to receiving any eye drops.

Patient's Signature

Date



RETINAL PHOTOGRAPHY EXAM

Primary Eyecare now employs a highly sophisticated computerized instrument that allows us to provide additional medical analysis of the inside layer of your eye, the retina. In 2007 The National Eye Institute reported that the occurrence of eye disease in Americans was increasing at a significant rate. Specifically, glaucoma, macular degeneration, and diabetic eye disease are expected to double by the year 2020. Every one of these conditions is painless and has no warning signs to the patient. The digital retinal photography examination can assist us in the early detection of these diseases and allow us to obtain a baseline to monitor your retinal health for comparison in the future.

We strongly recommend that all of our patients receive the retinal photography exam. It is especially important for people with:

(check all that apply)

- Headaches
- Spots or flashes in vision
- A family history of glaucoma, macular degeneration, diabetes, or high blood pressure
- High cholesterol
- Circulatory Problems
- A strong eyeglass prescription (increases risk for retinal detachment)

There is an additional fee for this procedure of **\$29.00**. If there is a diagnosis made, your insurance may help cover the cost. Please check the appropriate line below and sign at the bottom.

I choose to have the digital retinal photography exam performed.

I choose NOT to have the digital retinal photography exam performed.

Printed Name

Signature

Date

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