

Last Name _____ First Name _____ Middle Initial _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____ Do not text

Email _____ Sex M F Birthdate _____ - _____ - _____ Age _____

Social Security # _____ - _____ - _____ Marital Status: Married Single Divorced Widowed

Employment Status _____ Employer _____ Occupation _____

How did you hear about us? Insurance Referred By? _____ Internet _____

Yellow Pages Walk-In

Race White African American Hispanic Asian Native American Other _____

Preference Email Postal Mail Telephone Vision Insurance No Yes (name) _____

Do you have a Flexible Spending or Health Savings Account? Yes No (Rx sunglasses are eligible!)

Emergency Contact _____ Phone _____ Relationship _____

Sports/Hobbies _____

Eye doctors can bill your exam for **VISION** needs (glasses/contacts), or for **MEDICAL** needs (eye problems not related to glasses.) The **MAIN reason** you have come in today dictates the type of exam, and whether we must bill your **vision insurance** (VSP, EyeMed, VCP, etc.) or **medical insurance** (Medicare, BC/BS, etc.)

Check only ONE:

I'm here mainly for a glasses or contact lens exam. **Vision insurance** or discounts may be used if AccuVision Optical takes my plan, or I will pay for the visit myself. (My eye health will still be evaluated for disease.)

I'm here mainly for a medical concern about my eyes, like red or dry eyes, floaters or glare. **Medical insurance** may be filed, if AccuVision Optical takes my plan, or I will pay for the visit myself. (My glasses or contact lens Rx can still be provided. Note: With some insurance i.e. Medicare, there is a fee for this service.)

Primary Physician Name/Phone _____ Approx. Date of Last Physical Exam _____

Glasses: Do you currently wear glasses? Yes No (If yes, check all that apply below)

Distance Computer Multifocal Near OTC Readers Sunglasses

Are you planning on getting a pair of glasses and/or sunglasses today? Yes No Maybe

Contacts: Do you wear Contact Lenses?

Yes → Brand _____ Powers _____ Base Curve _____

Average time worn? Hours Per Day _____ Days Per Month _____

Do you sleep in your contact lenses? Yes No If Yes, how many nights in a row? _____

What brand of solution do you use? Biotrue Generic Optifree Renu Other _____

Do you have a current pair of glasses in case of trouble with your contacts? Yes No

No → Are you interested? Yes No

LASIK: Are you interested in learning about surgical/laser correction? Yes No Prior LASIK Date _____

Assignment of Benefits: I authorize release of any medical or other information needed for this or related insurance claims. I assign any benefits payable to Dr. Tupps or AccuVision Optical. I understand that I am responsible for payment of any balance not covered by insurance.

Payments: All required payments, co-payments and deductibles are due in full at the time the services are rendered or materials are provided, unless specific financial arrangements have been made prior to your appointment.

Notice of HIPAA Privacy Practices: I have been offered a copy of AccuVision Optical's Notice of Privacy Practices, effective April, 14, 2003.

Signature: I have read and understand the terms and conditions outlined above, and I hereby certify that the information I provided is accurate and true.

X _____ (Signature of Patient or Guardian) Date: _____

PATIENT EYE HISTORY

Do you currently have any of these issues? Or, have you had any of these issues in the past?

(Check all that apply)	Currently	In the Past
Allergy/Hayfever	<input type="checkbox"/>	<input type="checkbox"/>
Blurry Vision With Glasses/CLs	<input type="checkbox"/>	<input type="checkbox"/>
Corneal Abrasion	<input type="checkbox"/>	<input type="checkbox"/>
Crossed Eye/Eye Turn	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision (2 Images)	<input type="checkbox"/>	<input type="checkbox"/>
Dry Eye	<input type="checkbox"/>	<input type="checkbox"/>
Eye Fatigue/Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>
Eye Infections	<input type="checkbox"/>	<input type="checkbox"/>
Eye Injury/Trauma	<input type="checkbox"/>	<input type="checkbox"/>
Flashes of Light	<input type="checkbox"/>	<input type="checkbox"/>
Floater/Spots	<input type="checkbox"/>	<input type="checkbox"/>
Foreign Body in eye	<input type="checkbox"/>	<input type="checkbox"/>
Headaches (Frequent)	<input type="checkbox"/>	<input type="checkbox"/>
Itchy/Burning Eyes	<input type="checkbox"/>	<input type="checkbox"/>
Pain/Irritation	<input type="checkbox"/>	<input type="checkbox"/>
Red Eye	<input type="checkbox"/>	<input type="checkbox"/>
Sensitivity To Light	<input type="checkbox"/>	<input type="checkbox"/>
Vision Loss	<input type="checkbox"/>	<input type="checkbox"/>
Watery Eyes	<input type="checkbox"/>	<input type="checkbox"/>
Other Eye Problems _____		

FAMILY MEDICAL / EYE HISTORY *(Check all that apply)*

Have you or a blood relative been diagnosed?

	Self	Family History - Relationship to You
Blindness	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	_____
Cataracts	<input type="checkbox"/>	_____
Cornea Problems	<input type="checkbox"/>	_____
Eye Turn/Lazy Eye	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	_____
Macular Degen.	<input type="checkbox"/>	_____
Retinal Problems	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	_____
Other (Inheritable)		_____

Do you use? Tobacco Alcohol Other Substances

PATIENT MEDICAL HISTORY

Height _____ Weight _____ Last BP _____/_____

Current Medications (list ALL Rx, over the counter, eye drops & vitamins) _____

Allergies to Medications None Penicillin Sulfa
 Other _____

Are you pregnant? Yes No **Nursing?** Yes No

REVIEW OF SYSTEMS

Check &/OR LIST OTHER problems with any of these systems.

- Allergy _____
- Cardiovascular (high BP, cholesterol, heart disease...) _____
- Constitutional (appetite, sleep, thirst, fatigue...) _____
- Endocrine (diabetes, thyroid...) _____
- Gastrointestinal (acid reflux, ulcer, IBS...) _____
- Genitourinary (kidney disease, menopausal prostate...) _____
- Head (headache, ear/nose/throat, sinus...) _____
- Hematologic/Lymph (blood disorders, leukemia...) _____
- Immunologic (serious infection, HIV, hepatitis...) _____
- Integumentary (skin trouble, rosacea, lupus...) _____
- Musculoskeletal (rheumatoid arthritis, osteoporosis...) _____
- Neurological (Bell's palsy, MS, Parkinson's...) _____
- Psychiatric (depression, Alzheimer's, ADD, anxiety...) _____
- Respiratory (asthma, lung disease...) _____

Significant Surgeries/Hospitalizations and year? _____

Pupil Dilation Consent:

Dilation of the pupils is Florida's standard of care on all new patients, and is often done on subsequent visits. It makes the field of view wider, allowing a more thorough examination of the interior of the eye. This is essential to determine that your eyes are healthy. Pupil dilation may cause light sensitivity and blurred vision, especially up close. It usually takes 3-4 hours for vision to return to normal. During this time exercise caution when driving, walking down steps, operating machinery or performing other tasks that may present a risk of injury.

Your doctor may recommend dilation today. Although it is **highly recommended**, the decision to undergo dilation is yours.

The fee for dilation is included with a comprehensive exam.

- Agree:** I agree to have my pupils dilated at this time.
 - Decline:** I decline to have my pupils dilated at this time.
-

We're proud to offer state of the art care at AccuVision Optical. To complement our comprehensive ocular evaluations, you may elect to have one or both of the following tests.

We strongly recommend that all of our patients take advantage of this technology to ensure your eyes are as healthy as possible. Both tests are completely pain free and have no side effects. They take about 5 minutes each.

Visual Fields Examination:

Our FDT - Visual Field Tester electronically measures retinal function and sensitivity to light. This can assist us in early detection of many disorders, including glaucoma, brain tumors, diabetic retinopathy and retinal detachments.

The fee for the test is **\$15.00** and is not currently covered by vision insurance.

OCT Retinal Imaging:

We are now offering wellness retinal imaging. This scan combines a digital color image of your retina with a detailed laser scan of your central retinal layers and optic nerve.

Having an annual permanent record is valuable in assessing the health of your eyes and can help detect potential vision threatening diseases in their early stages, when they are most treatable.

OCT Wellness imaging is especially recommended if you elect NOT to have your pupils dilated, because it will give us an enhanced view of the inside of your eyes.

The fee for the Wellness Scan is **\$39.00** and is not currently covered by insurance.

- Agree:** I would like the Visual Field Test ONLY \$15
- Agree:** I would like the OCT Retinal Imaging ONLY \$39
- Agree:** I would like both tests ***Discount for both*** \$49
- Decline:** I decline the OCT Retinal Wellness Scan & Visual Field Test

X _____ (Signature of Patient or Guardian) **Date:** _____