

Patient Information

Name: _____ Today's Date _____

Address: _____

City: _____ Zip code: _____ Birth Date: _____

Home # _____ Work # _____ Cell # _____

S.S. # _____ E-mail: _____

Medical Insurance _____ Vision Insurance _____

Employer: _____

Marital Status (please circle one): Married Single Other

Parent(s) or Guardian _____

Last Eye Exam/Medical Exam: _____

How did you find out about us? _____

Reason for your visit (please check all that apply)

<input type="checkbox"/> Routine Check up.	<input type="checkbox"/> Broken or lost glasses
<input type="checkbox"/> Blurred Vision at distance	<input type="checkbox"/> Contact Lens Fitting
<input type="checkbox"/> Blurred Vision at near	<input type="checkbox"/> Other

Please list any medications that you are taking.

Please list any know allergies? : _____

Do you wear glasses? : _____

Do you wear contact lens? : _____

Do you difficulty seeing at night? : _____

Does the sun bother you a lot? : _____

Do you work on the computer? : _____

Please check all that apply to your self or family members.

	Self	Family		Self	Family
Diabetes	___	___	Cancer	___	___
High Blood Pressure	___	___	Heart Problems	___	___
Breathing Problems	___	___	Headaches	___	___
Kidney Problems	___	___	Flashes of Light	___	___
Thyroid Problems	___	___	Cataract	___	___
Arthritis	___	___	Blindness	___	___
Glaucoma	___	___	Dry Eye	___	___
Lazy Eye	___	___	Eye / head injury	___	___
Double Vision	___	___	Eye Pain	___	___
Pinguecula	___	___	Itching	___	___
Red Eye	___	___	Retinal Detachment	___	___
Spots in Vision	___	___			

**DILITATION INFORMATION AND CONSENT
AUTORIZACIÓN PARA INFORMACIÓN DE DILATACIÓN**

Pupil dilation is a highly recommended part of your complete eye examination.

(La dilatación de la pupila es altamente recomendada para su examen completo de visión.)

It allows the doctor to better examine the retina (the inside tissue of your eye) for detachments,

(Esto le permite al Doctor examinar mejor la retina (del tejido interior del ojo) por desprendimientos),

holes, tumors, leaking vessels, and other retinal problems. Dilation is mandatory for the following

(Perforaciones, tumores, escape en los vasos sanguíneos, y otros problemas de retina. La Dilatación es patients.

Mandataria para los pacientes con los siguientes problemas.)

1. Over 40 years of ege.
(Mayores de 40 años)
2. With high prescriptions
(Con prescripción de alto riesgo)
3. With histories of head or eye injuries
(Con historia de herida en la cabeza y ojos)
4. With Diabetes, High Blood Pressure, Herat Disease, or other systemic health conditions.
(Con Diabetes, Presión Alta, Problemas al Corazón, o cualquier otro problema de salud.)

Please sign the statement below giving or declining your permission for dilation.

(Por favor firme la declaración dada abajo para autorizar la dilatación de la vista.)

I understand the importance of pupillary dilation in detecting ocular diseases.

(Yo entiendo la importancia de la dilatación de pupila para detectar alguna enfermedad visual.)

_____ I give my permission for dilation.
(Yo doy mi permiso para la dilatación.)

_____ I do not give my permission for dilation today but
(No puedo autorizar la dilatación hoy pero prometo
promise to reschedule for dilation another day.
(hacer una cita para la dilatación en otro día.)

_____ I do not ever want to be dilated.
(No deseo nunca tener la dilatación.)

If you are under the ege of 18, your parent or guardian must sign one on the statements below:

(Si eres menor de 18, sus padres o guardianes deben firmar una de las declaraciones de abajo.)

_____ I give my permission for an eyeglass exam for my child.
(Doy autorización para el examen de ojos para lentes de mi hijo.)

_____ I give my permission for a contact lenses exam for my child and
(Doy autorización para el examen de lentes de contacto para mi hijo.)

**Please be advised of the following policies of this office. Contact lens Rx will not be given until
Por favor tome en cuenta el aviso de las pólizas de esta oficina. Formula de lentes de contacto
proper fit has been established and/or profesional services are paid in full. It is also the doctor's
no serán entregados hasta que el servicio prestado no halla sido pago en totalidad. Es también
policy not to be available during nonoffice hours.**

La póliza de oficina no prestar servicio en horas no estipuladas.

Authorization for Release of Health Information

By signing this authorization, I am giving my permission to Focal Point Optical to use and disclose certain vision-related health information concerning my exam, optical products purchased (e.g. eyeglasses) and demographic information (i.e. name, address and e-mail address). This information will only be used by Focal Point Optical for studies that track vision plans, benefits, products, and service purchased, as well as, for marketing purposes, such as promotional mailings or other means, that provide descriptions of products and services offered by this Location. Focal Point Optical will disclose this information to subcontractors to assist in performing the services described. I understand that Focal Point Optical Incorporation requires such subcontractors to safeguard this information and requires them not to share the information with any additional parties; however, further release of my information may occur and may not be held as confidential. Some of the companies that manufacture the products offered by the Location may provide financial assistance for the marketing activities. This information will not be sold to or used by any companies outside of Focal Point Optical for such companies' own marketing purposes.

If I choose not to sign this form, this Location will not refuse to provide service to me, will accept my managed vision benefits if this Location is a participating provider, and will submit such claims for payment on my behalf. If I revoke this authorization, I must notify this Location in writing. I agree that the change is not effective until I deliver such request in writing, and the change will not apply to actions already taken based on my earlier authorization.

If I desire to seek reimbursement from a third party payor, including my employer, health plan or plan sponsor, for the services and/or products received, I permit this Location to disclose my health information for the purpose of submitting a claim for payment to such payor.

This authorization shall expire 60 months from the date of my signature. I have read and understand this form and I acknowledge that I have been given a copy of this form for my records. I am voluntarily signing this form and authorize the use and disclosure of my health information as described above.

Signature: _____

Date: _____

or

_____ hereby represent that I am the Patient's

_____ parent, guardian, or legal representative (*circle one*) and that I am authorized as such to execute this authorization on the Patient's behalf.

Signature: _____

Date _____

* The expiration may be shorter depending on the state in which I live. In Connecticut, Maryland, and Minnesota, this authorization will expire 12 months from date of signature. In Maine and Montana, this authorization will expire 30 months from the date of my signature.

PATIENT LIFESTYLE SUPPLEMENT

Your responses to the following items will help us make the best recommendations for your eyecare, we look forward to providing you

Preferences and Interests

- 1) If you wear contact lenses, what kind? _____
- 2) What cleaning solutions do you use? _____
- 3) Have you ever been interested in color contacts? _____
- 4) If you don't currently wear contact lenses, have you ever tried them? _____
- 5) Would you be interested in a "test drive" of the latest in contact lens design? _____
- 6) Are you interested in thinner, lighter lenses if you wear glasses? _____
- 7) Do you prefer not to wear your glasses at times? _____
- 8) Would you like information on Laser Vision Correction? _____
- 9) Are you interested in a non-surgical approach to vision correction? _____

Current Satisfaction with your Vision

- 10) If you wear bifocals, are you bothered by the lines or head tilting?
Yes No
- 11) If you wear contacts, are you satisfied with the vision and comfort?
Yes No
- 12) If you wear glasses, are you satisfied with the vision and comfort?
Yes No
- 13) Do you have more than one pair of current prescription glasses?
Yes No

Lifestyle Factors

Do You... (check box if answer is yes)

- Work a lot at a computer?
- Spend time outdoors? (How much?) _____ hrs/wk
- Have prescription sunglasses?
- Have 100% UV protection in your sunglasses (whether prescription or not)?
- Have polarized lenses in your sunglasses (whether prescription or not)?
- Have children?
- Have family members in need of eyecare?
- Have hobbies that strain your eyes?
- Work in a hazardous environment such as manufacturing?
- Work around hazardous materials (bio or chemical hazards?)
- Have an east-west commute?
- Drive a lot at dusk, dawn or nighttime?
- Spend a lot of time in areas with low lighting?

Any other lifestyle factors that may be affecting your vision?

Visual Field Examination

A new highly sophisticated computerized instrument now allows us to provide a more thorough medical analysis of your eyes by testing visual field, or peripheral vision. Our new VISUAL FIELD INSTRUMENT electronically measures retinal functions and sensitivity to light. This evaluation of the visual field is important in detecting ocular disorders that reduce peripheral vision *before* central vision is affected such as in glaucoma, retinal disease and neurological disorders.

We strongly recommend that all of our patients over the age of thirty-five receive this test. It is especially important for those patients with the following:

- * **History / Family History of Glaucoma**
- * **Headaches**
- * **History of Diabetes**
- * **Circulatory problems / High blood pressure**
- * **High Myopia**
- * **High spectacle prescription**
- * **Visual flashes, floaters, or spots**

This procedure requires some additional examination time. The cost is \$ 80⁰⁰ for a basic screening or \$ 120⁰⁰ for an enhanced evaluation.

Please check the appropriate space below and sign.

I would like a Basic Visual Field Screening

If determined necessary by the Doctor, I would like the enhanced evaluation

I understand the importance of the Visual Field evaluation but, at this time, I prefer to have the routine eye examination only.

Patient's Signature _____

Date _____

Patient Responsibility Statement

Date: _____

I _____ understand that I am seeing

Dr. Regina McCollum Sullivan without

Verification / eligibility in services by _____
(Insurance company)

A required referral from my Primary Care Physician. (Medicaid/ HMO)

Other

I understand that if any eligibility can not be verified or if I do not obtain the proper Referral form when required, I will be financially responsible for payment of all charges incurred for services received from this doctor's office.

Signature of patient _____

Parent/ guardian signature (if minor) _____