Patient Information

Full Name: (First, Middle Initial, Last) _____

Date of Birth: _____ Age: _____ Marital Status: _____

Address _____ Home Phone: _____

City: _____ State: _____ Zip: _____ Cell Phone: _____

Employer: _____ Position: _____

E-mail Address: _____
(will be kept private and be used only to send a receipt or an appointment reminder)

Emergency Contact: (spouse, parent, etc.) _____

How did you hear about our practice? _____

Please answer the following questions to help us give you a complete and comprehensive examination. If you wear glasses or contacts, describe your vision with them on.
Thank you for your cooperation.

1. Any difficulty seeing clearly at a distance? (Y / N) How many days or months? _____
2. Any problem focusing clearly at close range? (Y / N) How many days or months? _____
3. Do your eyes? _____Burn _____Ache _____Tire _____Itch _____Water
4. Sensitive to light? _____ Yes _____ No
5. Do you wear eyeglasses? _____ Yes _____ No How old are they? _____
6. Hobbies: _____ Sports: _____
7. Do you work with a computer? _____ Yes _____ No
8. Have you ever worn contact lenses? _____ Yes _____ No
   If yes, what kind? _____ Soft _____ Hard
   Currently wearing contact lenses? _____ Yes _____ No
   Interested in learning more about the benefits of contacts? _____ Yes _____ No
9. Family Physician: _____
   Address: _____
   _____
   Phone Number: _____
10. Date of last eye and vision examination: _____
    Where? _____

Payment Policy

Payment for professional services is due upon completion of services. We do not bill services.

Please select your method of payment:

_____Cash _____Check _____Credit/Debit

*Returned check fee is $30.00

Contact lens service, for new or existing wearers, involves fees separate from those of non-contact lens wearers.

Authorization

I certify that I have read and understand the information given to me. Patient history questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

I understand the payment policy above.

I hereby authorize the physician to release information acquired in the course of my examination and treatment. I hereby assign payment directly to the designated physician for any procedures performed. This signature is valid until rescinded in writing at a later date. Also, I understand that I am responsible for any amount not covered by insurance. If any account should become delinquent, I agree to pay for any expenses including attorney's fees and court costs.

Patient Signature:_____ Date: _____
(Parent or Guardian if patient is under 18 years of age)

Patient Acknowledgement

The Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting us.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we are bound to our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this consent in writing, except where we have already made disclosures in reliance on your prior consent.

Patient's Name (print): _____

Patient Signature:_____ Date: _____
(Parent or Guardian if patient is under 18 years of age)

NEW PATIENT MEDICAL HISTORY QUESTIONNAIRE

(All responses are confidential medical information)

Name: _____ Date of Birth: _____

Who referred you? _____

Family Physician: _____ Date of Last Eye Exam: _____

PAST MEDICAL HISTORY

1. Eyes	Yes	No
Blurred Vision	❑	❑
Loss of Vision	❑	❑
Flashes and Floaters	❑	❑
Glare	❑	❑
Cataracts	❑	❑
Glaucoma	❑	❑
Macular Degeneration	❑	❑
Double Vision	❑	❑
Dryness	❑	❑
Itching	❑	❑
Burning	❑	❑
Foreign Body	❑	❑
Eye Pain	❑	❑

Other: _____

2. General	Yes	No
Fever	❑	❑
Weight loss	❑	❑

Other: _____

3. Ear, Nose, Throat	Yes	No
Sinus problems	❑	❑

Other: _____

4. Cardiovascular	Yes	No
Heart problems	❑	❑
Chest pain	❑	❑
High blood pressure	❑	❑

Other: _____

5. Respiratory	Yes	No
Asthma	❑	❑
Shortness of breath	❑	❑
Chronic cough	❑	❑
Emphysema	❑	❑

Other: _____

6. Gastrointestinal	Yes	No
Acid reflux	❑	❑

Other: _____

7. Genital, Kidney, Bladder	Yes	No
Kidney failure	❑	❑

Other: _____

8. Muscles, Bones, Joints	Yes	No
Arthritis	❑	❑

Other: _____

9. Skin	Yes	No
Acne	❑	❑
Skin cancer	❑	❑

Other: _____

10. Neurological	Yes	No
Headache	❑	❑
Seizure	❑	❑
Stroke	❑	❑
Alzheimer's	❑	❑

Other: _____

11. Psychiatric	Yes	No
Anxiety	❑	❑
Depression	❑	❑

Other: _____

12. Endocrine	Yes	No
Diabetes	❑	❑
Insulin	❑	❑
Oral Meds	❑	❑
Diet Controlled	❑	❑
Thyroid disease	❑	❑

Other: _____

13. Blood, Lymph	Yes	No
Cholesterol	❑	❑
Anemia	❑	❑

Other: _____

14. Allergic, Immunologic	Yes	No
Seasonal allergies	❑	❑
Lupus	❑	❑
AIDS	❑	❑

Other: _____

MEDICATIONS

- List all medications you currently take (***include eye medications and drops***):

_____

_____

_____

_____

_____

DRUG ALLERGIES

- List any drug allergies you have below:

_____

_____

_____

_____

PREVIOUS EYE SURGERY

- Include dates and the doctor that performed the surgery.

_____

_____

_____

_____

FAMILY HISTORY

- Have any of your parents, grandparents or siblings had any of the following?

	Yes	No	Relationship
Cataract	❑	❑	_____
Glaucoma	❑	❑	_____
Macular Degeneration	❑	❑	_____
Retinal Detachment	❑	❑	_____
Diabetes	❑	❑	_____
High Blood Pressure	❑	❑	_____
Stroke	❑	❑	_____
Heart Problems	❑	❑	_____
Cancer	❑	❑	_____

Other: _____

MISCELLANEOUS

- Do you wear glasses? ❑ Yes ❑ No How Long?_____
- Do you wear contact lens? ❑ Yes ❑ No How Long?_____
- Do you smoke? ❑ Yes ❑ No
- Do you drink alcohol? ❑ Yes ❑ No
- Are you interested in Lasik Eye Surgery? ❑ Yes ❑ No

History Reviewed By: _____ Date: _____

Physician's Signature

Informed Consent or Refusal for Dilated Fundus Exam

Dilation involves instilling eye drops for the purpose of enlarging the pupils of the eyes to better check the health of the inside of the eyes.

The pupils are simply an entry way/opening to the inside of the eye. Looking through an *undilated* pupil is similar to looking into a room through a keyhole in the door; the doctor may see only about 20% to 50% of what is inside. However, looking through a *dilated* pupil is like looking into a room through an open door; the doctor gets a complete view of the inside of the eye.

A dilated fundus exam is recommended at the time of your annual examination. Diabetics need to have an annual dilated examination. We will send a letter to the primary care provider of these patients summarizing the results.

Benefits

Dilation allows the doctor a better view of the peripheral retina for disease. It is highly recommended if you or your family has a history of high blood pressure, diabetes, past retinal problems (i.e., retinal detachment/tears), or extreme nearsightedness. It is also recommended if you have experienced sudden cloudiness of vision, especially in one eye, "curtain or veil-like" obstruction of vision, a sudden onset of many "floaters," or flashing lights off to the side of your vision.

Risks

- Some blurring of vision and glare because of enlarged pupils for about 2 (but up to 6) hours. You should not operate heavy equipment or drive an automobile unless you are comfortable with your vision.
- Difficulty with near reading for 1 to 2 hours. The focusing ability is impaired and may cause a slight headache if you try to read.

Please Check One:

❑ I understand the above and consent to have dilation done.

❑ I understand the above and decline dilation at this time. I understand that potential for partial or total loss of vision may exist and, without dilation, may go undetected.

I have read and understand the above.

Patient Signature:_____ Date: _____

(Parent or Guardian if patient is under 18 years of age)

iWellness Scan & Digital Retinal Photography

Kernersville Eye Associates is pleased to offer the **iWellness Scan** and **Digital Retinal Photography** to our patients. These advanced technologies can help detect vision threatening and systemic diseases in their very early stages when they are most treatable.

The **iWellness Scan** is a quick, non-invasive scan that allows us to see beneath the surface of your retina. **Digital Retinal Photography** allows for photo-documentation of the surface of your retina. Together they provide a more thorough retinal analysis of your eyes. Both are painless and neither cause side effects or light sensitivity. The scan and photos will become part of your medical record and can be compared to future scans and photos, allowing us to observe even the smallest amount of change.

Vision threatening diseases such as glaucoma, macular degeneration, and diabetic retinopathy often have no signs or symptoms in the early stages. We recommend that ALL patients have these procedures performed, and it is especially important for people who have a personal or family history of glaucoma, macular degeneration, diabetes, or other eye diseases. It is also beneficial to those who have borderline diabetes or high blood pressure, headaches, floaters, flashing light streaks, and a strong prescription for eyeglasses.

*****There are additional fees for these procedures*****

*****They do qualify as a FSA or HSA eligible expense*****

Please check the appropriate line and sign at the bottom:

_____ **Yes** I want to learn more about my risk for ocular disease. I elect to have **both** the **iWellness Scan** and **Digital Retinal Photography** to be performed: **$49.00**

OR

_____ **Yes** I elect to have the **iWellness Scan** performed only: **$29.00**

_____ **Yes** I elect to have **Digital Retinal Photography** performed only: **$29.00**

OR

_____ **No** I do not want the **iWellness Scan** or **Digital Retinal Photography**.
I understand I will not hold Kernersville Eye Associates, O.D., P.A. responsible for any pathology that is not found due to not having these procedures performed.

Patient Signature:_____ Date:_____

(Parent or Guardian if patient is under 18 years of age)