Warrenton Eye Center

(Please print the answers to all questions. Your information will remain confidential per HIPAA)

*We take **Medical Insurance and Vision plans** so kindly provide information for **Both** {Please Hand in cards to scan}*

❑Mr. ❑Mrs. ❑Miss ❑Dr. Sex: ❑ Male ❑ Female **If minor**, Parent/Guardian Name: _____

Name: _____ **Date**: _____
First Middle Last

Address: _____ **Apt #**_____ **City** _____ **State** _____ **Zip** _____

Cell Phone: _____ **Home Phone**: _____ **Work Phone**: _____

Date of Birth: _____ **Age**: _____ **Email Address**: _____

Occupation (or School Grade): _____ **Employer (or School)**: _____

Personal Eye History

What is the **reason for your visit** today? _____

Have you had **any of the following** problems? ❑ Blurred vision ❑ Red Eyes ❑ Glare ❑ Double vision ❑ Dryness ❑ Itching ❑ Allergies

❑ Tearing ❑ Macular Degeneration ❑ Floaters ❑ Flashes ❑ Headache ❑ Cataracts ❑ Glaucoma ❑ Retinal problem ❑ Eye Pain ❑ Injury

❑ Lazy eye ❑ Iritis/Uveitis ❑ Gritty feeling ❑ Light Sensitivity ❑ Crossed Eye/Eye Turn ❑ Twitching ❑ Other _____

Had any Eye surgery: ❑ None ❑ Lasik ❑ PRK ❑ Cataract ❑ Retina ❑ Glaucoma ❑ Eyelid ❑ Other _____

When was your **last exam**? (Approximately) _____ Doctor's Name/Location: _____

Family Eye History

Does anyone in your family have a history of any of the following problems?

❑ Macular Degeneration ❑ Glaucoma ❑ Retinal problems ❑ Crossed Eye ❑ Cataracts ❑ Other _____

Do you wear GLASSES? ❑ Yes ❑ No If YES, do you have them with you TODAY? ❑ Yes ❑ No

When do you wear your **GLASSES?** ❑ Full time ❑ Part time ❑ Reading ❑ Distance/ Driving ❑ Computer Use ❑ Safety

Hours per day on Computer, IPAD, Phone or Reading: ❑ 1-3 ❑ 3-6 ❑ 6+ HRS. Do your eyes burn/sting during these activities ❑Yes ❑No

Do you Wear CONTACTS? ❑ Yes ❑ No Have you EVER worn Contacts before ❑ Yes ❑ No

What Kind: ❑ Astigmatism/Toric ❑ Color ❑ RGP ❑ Scleral ❑ Bifocal ❑ Monovision ❑ Monthly ❑ 2 Weeks ❑ Daily Disposable

What is the **Brand and Power** of your old contacts: _____ Do you sleep in CONTACTS? ❑ Yes ❑ No

How often do you replace your lenses with new lenses? _____ End of day Dryness? ❑Yes ❑ No Contacts Blurry? ❑Yes ❑ No

Would you be interested in learning about the latest lens technologies? ❑Yes ❑ No

PLEASE TURN OVER AND FILL OUT BACK SIDE

Social History

BMI info: Height _____ft. _____in. Weight _____lbs. Race/ Ethnicity _____

Use tobacco? ❑ Yes ❑ No Are you pregnant? ❑ Yes ❑ No Breast feeding? ❑ Yes ❑ No

Personal Medical History *Many general medical conditions affect the eye and your vision*

Who is your Primary Care Doctor? _____

List all **medicines you take:** _____

_____

Do you have any **medication allergies:** ❑ None known ❑ Penicillin ❑ Sulfa drugs ❑ Other: _____

❑ Check this box **if NO medical conditions** apply listed below. Otherwise (*Please check all that apply in each box*)

Constitutional ❑ **None** ❑ Weight loss ❑ Fatigue ❑ Trauma ❑ Fever ❑ Cancer	**Neurological** ❑ **None** ❑ Multiple sclerosis ❑ Epilepsy ❑ Headaches ❑ Seizures ❑ Migraines	**Gastrointestinal** ❑ **None** ❑ Acid Reflux ❑ Colitis ❑ Ulcer ❑ Crohn's disease
Allergic/Immunologic ❑ **None** ❑ Drug allergy ❑ Environmental Allergy ❑ Rheumatoid arthritis ❑ Lupus	**Endocrine** ❑ **None** ❑ Type 1 Diabetes ❑ Type 2 Diabetes ❑ Thyroid disorders ❑ Hormonal Dysfunction	**Musculoskeletal** ❑ **None** ❑ Fibromyalgia ❑ Muscular dystrophy ❑ Osteoarthritis
Cardiovascular ❑ **None** ❑ Heart disease ❑ Stroke ❑ Vascular disease ❑ High Blood Pressure/HTN ❑High cholesterol	**Blood/Lymphatic** ❑ **None** ❑ Anemia ❑ Leukemia ❑ Bleeding Disorders	**Integumentary / Skin** ❑ **None** ❑ Eczema ❑ Rosacea ❑ Psoriasis ❑ Skin Cancer
Genital, Kidney, Bladder ❑ **None** ❑ Urinary tract infections ❑ Kidney concerns ❑ STD: Herpes, Chlamydia, ❑ HIV	**Psychiatric** ❑ **None** ❑ Depression ❑ Anxiety ❑ Insomnia	**Respiratory** ❑ **None** ❑ Asthma ❑ Bronchitis ❑ Emphysema ❑ COPD
Ears, Nose & Throat ❑ **None** ❑ Upper respiratory tract infection ❑ Sinus	❑ Premature at birth ❑ Other _____	❑ Other _____

Dilated Retinal Exam

As part of a Comprehensive Eye Exam, it is recommended to have your eyes Dilated. Drops are instilled so the doctor may see more peripherally in the back part of the eye. **It is especially recommended on your first eye exam, if you have Diabetes, High Blood Pressure, Previous retinal issues, Flashes / Floaters, or a very high nearsighted prescription in your glasses**. This procedure does take an **additional 30 minutes** and will blur your eyes significantly at near for 4-6 hours. Some people do not feel comfortable driving after dilation due to light sensitivity and some slight distance blurriness. ***The dilation is not included in some insurances or the basic wellness exam and is a $30 additional fee.*** The Doctor may require you to dilate your eyes based on findings during the exam to get an accurate health diagnosis.

[ ] I would like to DILATE my eyes today [ ] I would NOT like to Dilate my eyes today [ ] I will reschedule Dilation

Insurance Information Release

When making a third party claim, I authorize the release of my medical information to process my third party claim. I authorize Hidef Eyecare Center/ Anup Panjwani, O.D. to file complaints on my behalf if my third party carrier does not properly handle my claim. I authorize the release of any information to pertinent to my case to any third party, adjuster or attorney involved in resolving the financial status of my account. I authorize my third party plan to Hidef Eyecare Center/ Anup Panjwani, O.D. directly. If my plan does not pay this claim, I agree to be responsible for the payment of these professional services.

Signature_____ **Date**_____

Acknowledgment of Privacy and Voluntary Consent Form

In providing services to you, we create, receive, and store health information that identifies you. It is often necessary to use and disclose this information in order to treat you and conduct healthcare operations involving our office. The *Notice of Privacy Practices* posted in our office describes these uses and disclosures in detail. Please refer to this notice any time prior to signing this Consent Form. Copies are available for your personal documents.

I have read this Receipt and Consent Form and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment and healthcare options.

_____

Signature

If you are signing as a personal representative of the patient, please indicate your relationship to the patient and print your name.

Relationship to patient _____ **Print Name** _____