WELCOME TO OUR OFFICE

Date _____ Please Print First Visit (Y/N) _____

Patient's Name _____ Sex (M/F) ____ Age ____ Date of Birth _____ / _____ / _____ Married (Y/N) _____

Address_____ City _____State _____ Zip_____

Phone (_____) _____ Cell (_____) _____ Social Security # _____-_____-_____

Email _____ If Married, Name of Spouse _____

If Child, Parent's Name _____ S.S.# _____-_____-_____ D.O.B _____/ _____/ _____

Place of Employment/School _____ Business Phone (_____) _____

Occupation _____

Vision Care Plan _____ Other Group Health Plan and Insurance _____

Insured's Name _____ S.S.# _____-_____-_____ D.O.B _____/ _____/ _____

Does your work require special vision care? _____ If yes, please explain _____

List Activities / Hobbies _____

Date of Last Exam: _____ Where_____ Do you wear contact lenses? ☐ Yes ☐ No Type_____

Doctor _____ Are you interested in wearing contact lenses? ☐ Yes ☐ No

Reason for Today's Visit: _____

How were you referred to our office?_ _____

MEDICAL HISTORY:

Medical Doctor _____ Last visit _____ Phone (_____) _____

Do you Have (Past or Present)? Do you ____Smoke ____Drink ____Use Drugs

_____ Heart Disease	_____ Diabetes	_____ Major illness	Medications: _____
_____ High Blood Pressure	_____ Lung Disease	_____ Surgery	_____
_____ Kidney Problems	_____ Cancer	_____ Arthritis	_____
_____ Ulcers	_____ Asthma	_____ Cholesterol	List Allergies: _____
_____ Thyroid Problems	_____ Sinus Problems	_____ Depression	_____
_____ Headaches	_____ Allergies	_____ Other	_____

Does Anyone in Your Family Have?

_____ Diabetes	_____ Cancer	_____ High Blood pressure
_____ Heart Disease	_____ Lung Disease	_____ Other

OCULAR HISTORY:

Do You have (Past or Present)?

_____ Glaucoma	_____ Blurred vision	_____ Flashes	_____ Watering	_____ Trauma
_____ Cataracts	_____ Double Vision	_____ Eye Fatigue	_____ Redness	_____ Surgery
_____ Blindness	_____ Floaters	_____ Itch	_____ Eye Turn	_____ Disease

Does Anyone in Your Family Have?

_____ Glaucoma	_____ Blindness	_____ Macular deg.	_____ Eye disease	_____ Other

It will be necessary to dilate your pupils in order to perform a complete and thorough eye examination. This allows the doctor to obtain a better view of the back of your eyes. The dilating drops typically last 3-4 hours. During this time you may find it difficult to focus at near and you may be sensitive to light.
You will be provided with post-dilation sunglasses. We strongly recommend caution when driving or operating equipment or machinery after dilation. If you feel you would not be able to drive or return to work, we can reschedule the dilated portion of your exam.
UNDERSTANDING THE RISKS AND BENEFITS OF DILATION: I ACCEPT REFUSE Dilation.
In the event that it becomes necessary for us to release your records to or request your records from another healthcare professional, your written permission is required. Please read and sign below.

PATIENT SIGNATURE (Patient or Guardian): _____

IF APPLICABLE I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE OR OTHER INSURANCE BE MADE EITHER TO ME OR ON MY BEHALF TO PRITCHETT EYE CARE ASSOCIATES FOR ANY SERVICES RENDERRED TO ME. I AUTHORIZE PERTINENT MEDICAL INFORMATION ABOUT ME, TO DETERMINE INSURANCE BENEFITS AND BILLING TO BE RELEASED TO THE HEALTH CARE FINANCING OR OTHER INSURANCE AGENCIES.
I UNDERSTAND I AM RESPONSIBLE FOR ANY CHARGES NOT COVERED BY MY INSURANCE COMPANY.

It is policy of this office to require:

1.) Payment in full or at least one-half before the order can be placed.
2.) The balance of the fee must be paid at the time the order is dispensed.
3.) A $25.00 charge will be assessed for returned checks.
4.) All orders are final when placed.

WE THANK YOU FOR TAKING THE TIME TO COMPLETE THIS FORM AND FOR CHOOSING US TO PROVIDE YOUR VISION / EYE HEALTH CARE.

PATIENT SIGNATURE (Patient or Guardian): _____ DATE _____