

WELCOME TO OUR OFFICE

Date _____ Please Print _____ First Visit (Y/N) _____
Patient's Name _____ Sex (M/F) ____ Age ____ Date of Birth ____ / ____ / ____ Married (Y/N) _____
If Child, Parent's Name _____ S.S.# _____ - _____ - _____ D.O.B ____ / ____ / ____
Address _____ City _____ State _____ Zip _____
Phone (_____) _____ Cell (_____) _____ Social Security # _____ - _____ - _____
Place of Employment/School _____ Business Phone (_____) _____
Occupation _____ Medicare # _____
Other Group Health Plan and Insurance # _____ Vision Care Plan _____
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? _____
Method of Payment: Cash Check Credit Card Other _____

MEDICAL HISTORY:

Medical Doctor _____ Last visit _____ Phone (_____) _____
Do you Have (Past or Present)?
_____ Heart Disease _____ Diabetes _____ Major illness
_____ High Blood Pressure _____ Lung Disease _____ Surgery
_____ Kidney Problems _____ Cancer _____ Sickle Cell
_____ Ulcers _____ Asthma _____ Other
_____ Thyroid Problems _____ Sinus Problems
_____ Headaches _____ Allergies
Medications: _____
List Allergies: _____
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.

I HEREBY REQUEST RELEASE OF MY MEDICAL/CONTACT LENS RECORDS TO / FROM DR. PRITCHETT / SIEBERT/ BENITZ / HUBBARD / PATTERSON / SOLBERG / CANNON

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 RENDERED 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 _____