

WELCOME TO PRECISE EYECARE

Last Name _____ First Name _____ MI _____

Address _____ Home Phone _____

City, State, Zip _____ Alternate Phone (work/mobile) _____

Date of Birth _____ Age _____ Sex _____ Referred by _____

Occupation _____ Employer _____ Vision insurance _____

Date of last eye exam _____ Name of last Eye Doctor _____

Have you ever worn contact lenses? Yes No

Are you interested in contact lenses? Yes No If so, what type? _____

Reason for your visit today: _____

Do **you** or anyone in your **immediate family** have a history of the following:

High Blood Pressure	<input type="checkbox"/> Self <input type="checkbox"/> Family	Glaucoma	<input type="checkbox"/> Self <input type="checkbox"/> Family
Diabetes	<input type="checkbox"/> Self <input type="checkbox"/> Family	Cataract(s)	<input type="checkbox"/> Self <input type="checkbox"/> Family
Heart condition	<input type="checkbox"/> Self <input type="checkbox"/> Family	Eye Injury/surgery	<input type="checkbox"/> Self <input type="checkbox"/> Family
Thyroid	<input type="checkbox"/> Self <input type="checkbox"/> Family	Eye disease	<input type="checkbox"/> Self <input type="checkbox"/> Family
High Cholesterol	<input type="checkbox"/> Self <input type="checkbox"/> Family	Other _____	<input type="checkbox"/> Self <input type="checkbox"/> Family
Pregnant	<input type="checkbox"/> Self		

List any medications you are taking: _____

List any allergies you have: _____

We are committed to early detection and prevention of eye diseases. We strongly recommend that all of our patients receive the dilation as part of their comprehensive vision examination.

A **dilated fundus exam** allows the doctor a more thorough examination of the inside of the eye. A dilated exam can uncover conditions within the eye that may not be detected during a basic eye exam and is strongly encouraged if the patient is diabetic, hypertensive, has a high nearsighted prescription, or a family history of eye disease. The side effects are blurred near vision and light sensitivity for a few hours. In some individuals, distance vision may also be affected. The additional fee for this test is **\$15**.

I **DO** want the dilated fundus exam.

I do **NOT** want the dilated fundus exam.

I understand that without these tests certain eye diseases and conditions may not be discovered. I agree to assume all risks associated with refusing these tests and release Precise Eyecare from any and all claims or liability whatsoever related to failure to diagnose and/or treat any eye condition due to lack of diagnostic information which could have been obtained with these tests.

ALL FEES FOR PROFESSIONAL SERVICES ARE NON-REFUNDABLE AND PAYABLE AT TIME OF SERVICE.

Signature _____ **Date** _____

Relationship to patient (if patient is a minor) _____

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA PRIVACY POLICY

I, _____ [please print name] (the "Patient" or "Patient's legal representative"), have been presented with the Notice of Privacy (the "Policy") of Precise Eyecare (the "Provider"), and have been offered a copy of such a policy to keep for my records at my request.

Signature _____ Date _____