Patient Registration And Health Form

Date_____

Patient Name_____
Age/ Date of Birth _____
Sex ____Male ____Female
Parent or Guardian's Name_____
Marital Status_____

Mailing Address_____
Apartment number/unit_____
City_____ Zip Code_____
Home Phone_____ Work Phone_____
Cell Phone_____E-mail:_____

Occupation/ Employer_____
Vision Insurance Plan_____
Social Security Number_____

Referred by_____
What is the reason for seeking care at this time?_____
_____
Do you wear glasses or contacts or both?_____

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1. Date of last eye exam/ Previous Doctor's Name_____
2. Do you have any history of eye injury, eye surgery, or eye disease? If so please list these with date of diagnosis:_____
   _____
3. Do you have any of the following conditions: eyestrain, double vision, turned eye, flashes/floaters/spots, poor color vision, severe headaches, dry/itchy/ red eyes? If so, please list which ones:_____
4. Date of last dilated exam:_____
5. Do you have any medical diseases/conditions? If so please list these with date of diagnosis:_____
   _____
   _____
6. Are you taking any medications? If so, please list these:_____
   _____
   _____
7. List any allergies (to medication, food, other allergens):_____
   _____
8. List any Family Eye History of glaucoma, blindness, or hereditary eye diseases:_____
   _____
9. List any Family Medical History of diabetes, high blood pressure, or heart disease_____
   _____

10. Are you pregnant? _____Yes _____No

Dilation

Dilation of the eyes utilizes the use of dilation drops to temporarily increase the size of your pupils in order to perform a more thorough medical analysis of your eyes. Dilation assists us in the early detection of many disorders including glaucoma, retinal detachments, macular degeneration, and brain tumors; and, is considered part of a comprehensive eye exam.

It will usually take 3-5 hours for the effects of the drops to wear off. In the meantime, your ability to focus up close may become more difficult and you will be more sensitive to light. Wearing sunglasses outdoors will increase comfort.

We strongly recommend that all our patients undergo routine dilation. It is especially important for patients who have:

1. diabetes
2. high blood pressure
3. circulatory problems
4. headaches
5. floaters
6. flashes of light
7. high myopia (i.e., high nearsightedness)
8. are 35 years of age or older
9. a family history of glaucoma or blindness
10. never had a dilated eye exam

There is an additional charge of $30.00 for this procedure. However, this is covered under most insurance plans.

Please check the appropriate line below and sign at the bottom.

( ) I **DO** want this procedure.
( ) I **DO NOT** want this procedure.

_____
Patient's Signature

_____
Date

VISION DESIGNS OPTOMETRIC CENTER, INC.

ACKNOWLEDGEMENT OF THE

90-DAY CONTACT LENS POLICY

This notice describes the ninety-day contact lens policy. Filling the contact lens prescription constitutes an agreement to remake the contact lens prescription at the doctor's direction for a period of 90 days without charge to the patient. We understand that some contact lens fittings may take several visits or more. The Patient acknowledges that this office will provide contact lens fitting(s) up until 90 days from the initial eye exam. After 90-days, the Patient will be charged $20 per visit for any additional contact lens fitting(s) up to 6 months. After 6 months, the Patient will be required to pay for another eye exam, including the contact lens fitting.

The Patient acknowledges that he or she will adhere to the ninety-day contact lens policy.

Signature: _____ Date: _____

Patient: _____