

Welcome to Atlanta Eye Care!

Date____/____/20_____

Patient name _____ DOB _____ Age _____ Sex _____

Address _____ City _____ State _____ Zip _____

SSN _____ - _____ - _____ **Circle Best Number to Reach you at: Home Cell Work**

Home _____ Cell _____ Work _____

Email Address _____

Marital Status _____ Occupation _____ Employer _____

Vision Insurance Company _____ Medical Insurance Company _____

Relation to Insured _____ Member Name _____

Member DOB _____ Member SSN _____ - _____ - _____

Member Employer _____

Name of person responsible for account _____

How did you hear about our office? _____

Health History

1. Reason for today's exam _____

2. Date of last exam _____ Name of eye doctor _____

3. Do you or anyone in your immediate family have a history of the following?

Yes _____ No _____. If Yes Who? _____

- | | | |
|------------------------------------|--|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Blindness | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Turned or lazy eye |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Heart Condition | |

4. Do any of the following conditions apply to you? Yes _____ No _____

- | | | |
|---|---|---|
| <input type="checkbox"/> Frequent headaches | <input type="checkbox"/> Drug Allergies | <input type="checkbox"/> Pregnant |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Recently had a child |

5. Please list all medications you are currently taking _____

6. Do you have any known medication allergies? _____

Other allergies? _____

7. Have you ever had any of the following conditions involving your eyes? Yes _____ No _____

- | | | |
|--|--|--|
| <input type="checkbox"/> Eye Surgery | <input type="checkbox"/> Severe pain | <input type="checkbox"/> Eye infection/disease |
| <input type="checkbox"/> Medical treatment | <input type="checkbox"/> Light sensitivity | <input type="checkbox"/> Double vision |
| <input type="checkbox"/> Eye injury | <input type="checkbox"/> Floaters/spots | <input type="checkbox"/> Poor near vision |
| <input type="checkbox"/> Burn/itch/water | <input type="checkbox"/> Eye strain | <input type="checkbox"/> Poor distance vision |

Please Explain _____

8. Do you currently wear glasses? Yes _____ No _____

If yes, what type? Reading only, Distance only, Progressive(No line Bifocal), or Bifocal

9. Have you worn contacts before? Yes _____ No _____ Brand _____

10. Do you wish to continue wearing contacts? Yes _____ No _____

(The state of GA requires that a contact lens evaluation be done every 12 months to update your contact lens prescription in order to maintain the health of the eye. This applies to all patients even though you may have worn contacts in the past or even if the prescription doesn't change. Contact lens evaluation fees are not included as part of your comprehensive exam charge.)

Initial _____ **OVER PLEASE —>**

11. Do you work at a computer or video terminal? _____

13. What hobbies or sports do you enjoy? _____

Review of Systems

14. What is your general health condition? _____

15. Do you have any problems with any of these systems? **Yes** _____ **No** _____

- | | | |
|---|--|---|
| <input type="checkbox"/> Gastrointestinal | <input type="checkbox"/> Nervous | <input type="checkbox"/> Mental |
| <input type="checkbox"/> Ear/nose/throat | <input type="checkbox"/> Genitourinary | <input type="checkbox"/> Endocrine (glands) |
| <input type="checkbox"/> Cardiovascular | <input type="checkbox"/> Musculoskeletal | <input type="checkbox"/> Blood/lymph |
| <input type="checkbox"/> Respiratory | <input type="checkbox"/> Skin | <input type="checkbox"/> Allergic/Immunologic |

16. Do you use cigarettes/tobacco? _____ Alcohol? _____ Rec. Drugs? _____

17. Name of family Doctor _____ Last Visit _____

Dilation/Decline Waiver

18. Our standard of care is to dilate every patient at each comprehensive exam. This allows the doctor to obtain a superior view of the health of the retina and associated systemic issues. It is included with your complete exam at no extra charge. It is your option to decline this procedure. If you have questions, please ask the front desk or Doctor during your exam.

Please Check Yes or No

___ **Yes**, I wish to accept your recommended standard of care for dilation.

___ **No**, I wish to decline dilation today.

Scanning Laser Ophthalmoscope

Our practice has purchased the Heidelberg Scanning Laser Ophthalmoscope that provides an instant view of your internal ocular health. This instrument represents our commitment to the most advanced diagnostic equipment available and is a tremendous step forward in our diagnostic capabilities. The Scanning Laser Ophthalmoscope aids us in establishing a baseline for your ocular, as well as, general health. We will compare these initial images with future images to monitor any abnormal changes. This instrument helps with an earlier diagnosis of many eye, neurological, and general health conditions. Most of these conditions can result in permanent vision loss if not caught and treated in a timely manner.

We recommend this procedure for every patient on every visit. The \$ 22.00 fee for these images is not covered by any vision plans and represents your investment in your ocular health. It is especially important for patients with high blood pressure, a history of diabetes, circulatory problems, a family history of Glaucoma, or macular degeneration. If you have these underlying health conditions, then we can bill your major medical insurance plan with your authorization.

Please check Yes or No

_____ **Yes**, I would like to have Scanning Laser Ophthalmoscopy

_____ **No**, I elect not to have Scanning Laser Ophthalmoscopy

It is your responsibility to read and understand your own insurance policy. Certain services and procedures may or may not be covered by your insurance. It is your responsibility to contact your insurance company to find out whether Drs. Lundy, Arey, Alexander, Knouff and Walker are participating providers. In closing, insurance information must be presented at the time of service. **WE CANNOT BACK DATE SERVICES.**

This office is HIPPA compliant. A copy of the Privacy Information Practice is available at your request.

Signature _____ Date _____