Please list any past and present eye problems. (Describe present symptoms and any prior eye surgery with dates)

List all EYE medications and describe how they are being used and in which eye:

Do you smoke? Do you drink? If so, how much? Did you have the flu vaccine?

Did you have the pneumonia vaccine? Any falls in the past year?

List any family history of eye problems (i.e. glaucoma, retinal problems, cataracts, eye muscle problems, etc.)

Do you wear glasses? How old is your present prescription? Do you wear contact lenses?

Are you ALLERGIC to any drugs or medications? (Please list names)

Do you have any of the following conditions: (all information will be confidential)
DIABETES/APPROXIMATE DIAGNOSIS YEAR? HEART PROBLEM?
HIGH BLOOD PRESSURE? HIV POSITIVE? Any other medical conditions (please list)?

REVIEW OF SYSTEMS – Please circle if you have any of these problems.	
GI	Nausea/ vomiting/ diarrhea/ weight loss/ appetite loss/ blood in stools
HEART/LUNG	Asthma/ chest pain/ shortness of breath/ cough/ irregular heart beat
GU	Pain on urination/ blood in urine/ incontinence/ discharge
HEENT	Headaches/ hearing loss/ sore throat/ voice change
SKELETAL	Joint pain/ muscle pain/ back pain
SKIN	Rashes/ bruises/ new skin lesions
NEURO	Headache/ blackouts/ seizures/ dizziness/ numbness or tingling

Do any of your family members receive care in our practice? (List names)

List any major surgery (other than eye surgery and include approximate dates

List any medications that you may be taking (other than eye medications) or provide a list to the receptionist

PATIENT AGREEMENT

REFRACTION CHARGES:

"Refraction" is a procedure necessary for our physicians to evaluate your vision and/or write you a prescription for glasses. If you are experiencing blurred vision or decreased visual acuity as measured by the eye chart, refraction would help determine whether the difficulty is associated with a medical problem or a need for glasses. During the refraction, the physician or technician offers you a series of lens choices to determine which prescription provides the clearest and sharpest vision. Ophthalmic medical assistants are responsible for many of the measurements involved in this process, but the doctor alone provides the judgment needed to verify the results, assess patient needs, and prescribe the appropriate final correction.

Many insurance companies (including **Medicare**), do not cover the refraction test, and **Medicaid** specifically excludes refractions as a covered benefit. If your insurance does not cover this test, then Perlmutter Eye Center offers a time-of-service discount of 40%. Therefore, if you pay today, your out-of-pocket expense is $30. If you cannot pay today, your charge will be sent through our billing service and you will be billed the full fee of $50. **If you wish to decline the refraction, please make the technician aware.**

Initials___________ Date_____________

RETURN APPOINTMENTS:

I understand that I may be given a return appointment in order to follow-up on my eye status or condition. In the event that, for any reason, I do not keep that appointment and do not promptly reschedule, I agree not to hold Perlmutter Eye Center, it's Physicians, and/or staff responsible for any resulting consequences. Appointments cancelled with less than 24 hours notice may be charged to my account.

Initials___________ Date_____________

PRIVACY POLICIES:

I have reviewed Perlmutter Eye Center's "Notice of Privacy Practices" explaining how the privacy of my health information is maintained, how my health information may be used, and how my health information may be disclosed.

Initials___________ Date____________