

ADVANCED
EYECARE CLINIC^{INC}
Patient Information

Patient's Name _____

Street Address _____

City, State, Zip Code _____

Home Phone Number _____ Cell or Work Number _____

Email address (we will not sell/distribute) _____

Date of Birth ____/____/____ Age _____

Employer _____ Occupation _____

Spouse's Name _____ Employer _____

Physician Name/City _____

How did you hear of our practice? _____

Who will be responsible for the financial aspect of this case? Same as above.

Person's Name _____

Street Address _____

City, State, Zip Code _____

Place of Employment _____

Bill payer's SS#/Medicare # _____

Insurance Carrier's Name _____

ID Number _____ Group Number _____

Insurance Holder's Date of Birth ____/____/____

Insurance Assignment, Release and Notice of privacy practices.

I certify that if I and/or my dependents have insurance coverage; I assign them directly to Advanced Eyecare Clinic, Inc. all insurance benefits, for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

I authorize Advanced Eyecare Clinic, Inc to release any information including diagnosis and the records of any treatment or examination, of me or my dependents, during the period of care to third party payers and/or health practitioners. I acknowledge that I have been offered the Notice of Privacy Practices and have been provided an opportunity to review it. The information provided on this form is accurate to the best of my knowledge.

Signature _____ Date _____

Name: _____ Date: _____

Where and when was your last eye exam? _____

Do you presently have any problems in the following areas? If YES, give an explanation.

| Eyes | YES | NO | EXPLANATION OF PROBLEM |
|---------------------------------------|-----|-----|------------------------|
| Loss or blurred vision | [] | [] | _____ |
| Loss of side vision, double vision | [] | [] | _____ |
| Itching, burning or discharge | [] | [] | _____ |
| Redness | [] | [] | _____ |
| Gritty feeling, dryness or tearing | [] | [] | _____ |
| Glare/light sensitivity, or halos | [] | [] | _____ |
| Eye pain or soreness | [] | [] | _____ |
| Infection of eye lashes, lid or styes | [] | [] | _____ |
| Experience flashes of light | [] | [] | _____ |
| Problems with night vision/driving | [] | [] | _____ |

Medical History

| | | | |
|-------------------------------|-----|-----|-------|
| Allergies Drug/Environmental | [] | [] | _____ |
| Arthritis/Joint Pain | [] | [] | _____ |
| Breathing Problems/Asthma | [] | [] | _____ |
| Cancer | [] | [] | _____ |
| Diabetes | [] | [] | _____ |
| Heart Problems | [] | [] | _____ |
| Headaches/Migraines | [] | [] | _____ |
| High Blood Pressure | [] | [] | _____ |
| Kidney Disease | [] | [] | _____ |
| Pregnancy/Nursing | [] | [] | _____ |
| Thyroid Disease | [] | [] | _____ |
| Other general health problems | [] | [] | _____ |

Medications currently in use [] [] _____

Social History

| | | | |
|--|-----|-----|--------------------------|
| Do you work at a computer terminal? | [] | [] | _____ |
| Are you a cigarette smoker? | [] | [] | How much per day? _____ |
| Do you currently use recreational drugs? | [] | [] | _____ |
| Do you drink alcohol? | [] | [] | How much per week? _____ |

Past History (Eye)

| | | | |
|-------------------------------|-----|-----|-------|
| History of cataract, glaucoma | [] | [] | _____ |
| History of crossed/lazy eye | [] | [] | _____ |
| Eye injury or other disease | [] | [] | _____ |
| Eye surgery | [] | [] | _____ |

Family History

| | | | |
|-------------------------------|-----|-----|-------|
| Blindness | [] | [] | _____ |
| Cataract | [] | [] | _____ |
| Glaucoma | [] | [] | _____ |
| Macular degeneration | [] | [] | _____ |
| Retinal detachments | [] | [] | _____ |
| Diabetes | [] | [] | _____ |
| High blood pressure | [] | [] | _____ |
| Other general health problems | [] | [] | _____ |

Patient's Signature: _____

Date: _____



Dilation of the Pupils

One of the most important tests that Dr. Rocks of Advanced Eyecare Clinic does as part of a regular eye exam is to look inside of your eyes. Many health problems of both the eyes can often be detected this way.

Much more of the inside of your eyes can be examined if special eye drops are used to temporarily dilate (enlarge) your pupils (the center black part of your eye). The Doctor will put eye drops into your eyes, and then about 20 to 30 minutes later (most patients choose to pick out glasses during this time), he will examine the back of your eye. Unfortunately, the dilation will increase your sensitivity to bright light for about 4 to 6 hours. We can provide disposable sunglasses for this time. The drops will also probably decrease your close vision for 2 to 3 hours. Keep in mind, driving or returning to work or school may be difficult during this time.

The Doctor recommends that all patients have their eyes dilated to examine for diseases and disorders that may lead to future vision problems or even blindness. The following groups of people are in the greatest need of regular dilated examinations:

- Diabetic patients
- Patients with High Blood Pressure
- Anyone 50 years of age and older
- People with a family history of eye disease or blindness
- Nearsighted people with a strong prescription
- Anyone experiencing unexplained flashes of light and/or an increase in floaters in their eyes

Please indicate below if you would like to have your eyes dilated. If you have any questions, please feel free to speak to the Doctor. Thank you.

_____ Yes, Today if possible

_____ Yes, I can't today, but I will set up an appointment

_____ No, I prefer not to be dilated

Patient Signature _____
(Parent or guardian's signature if patient is a minor)

Date _____