

Date _____

WELCOME TO OPTOM~EYES - PLEASE PRINT LEGIBLY AND COMPLETE ALL ITEMS

Patient's Name _____
Legal Last First MI Name patient prefers to be called

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____
Please circle: Patient / Mother / Father / Guardian Patient / Mother / Father / Guardian

e-mail _____ Name of guarantor (required if patient is a minor) _____
Guarantor's if patient is a minor

Patient's Sex (circle one): M / F Patient's Marital Status (circle one): Single / Married / Divorced / Other

Patient's Date of Birth _____ Patient's Social Security Number _____

Patient's Employer/School _____ Patient's Occupation _____

PATIENT'S QUESTIONNAIRE: Have you been seen before at OPTOM~EYES? Yes / No When? _____

How did you hear about OPTOM~EYES? _____ Date of Last Eye Exam _____
Where? _____

Any problems with your vision? _____ Do you wear contact lenses? Yes / No
Are you interested in contact lenses? Yes / No

List any health problems _____

What medications do you take? _____

Allergies to medications _____ Have you ever fainted? _____

Name of primary care doctor _____ Primary doctor phone _____

CIRCLE ALL THAT APPLY TO YOU:

- | | | | | |
|------------------------------|---------------------------|---------------------------------------|-------------------------|-------------------|
| <i>Burning/Itchy Eyes</i> | <i>Double Vision</i> | <i>Headaches</i> | <i>Spots (floaters)</i> | <i>Diabetes</i> |
| <i>Eye Disease/Infection</i> | <i>Eye Injury/Surgery</i> | <i>Temp. Loss of Vision (One Eye)</i> | <i>Pregnant</i> | <i>ARMED</i> |
| <i>Lazy (or Turned) Eye</i> | <i>Eye Pain</i> | <i>Flashing Lights</i> | <i>Smoker</i> | <i>None Apply</i> |

DILATION CONSENT: The use of dilating drops is the standard for the most thorough eye examination; it is the only way of providing a complete ocular health assessment. You may experience increased light sensitivity and some difficulty seeing up close, although there is generally little effect on distance vision. These effects can last anywhere from 2 to 5 hours. There is no additional fee for dilation.

CHECK ONE, PLEASE: I accept dilation _____ I decline dilation _____ I'd like to reschedule dilation _____

CONTACT LENS SERVICES: The initial fitting fee (additional to the routine exam fee) covers follow-up visits during the trial period (up to a month) - additional appointments will be billed as routine office visits.

RETINAL IMAGING AUTHORIZATION (Please review attached information sheet prior to completing this part):

Dr. Rabins recommends retinal screening for all of his patients and will perform this photographic exam at an additional cost to the conventional comprehensive eye exam being performed today. Please select one of the following boxes.

I'D LIKE TO have my/my dependent's retinal health evaluated with retinal imaging. I understand that I will be billed \$26 separately for this service.

I DO NOT wish to have retinal imaging. I understand that I/my dependent will still have a thorough eye examination with ordinary slit lamp and indirect biomicroscope observation.

Patient's Name Signature of Patient or Parent/Guardian