Exam Date:_____ Exam Date:_____ Exam Date:_____

Patient's Name:_____ Patient's DOB:_____ ☐M ☐F

Patient's Address:_____City/State/Zip: _____

Patient's Phone:_____ Email: _____

Please list medications the patient is taking (including oral contraceptives, aspirin, over the counter medication, & home remedies): _____

Please list anything the patient is allergic to: _____

List any major eye injuries or eye surgeries the patient has had: _____

List any relevant family medical history: _____

Employer/Occupation: _____

How did you hear about us? _____

Has the patient ever worn (circle): Glasses/Contacts/None

Hours on a computer/phone/tablet per day: _____

Are you pregnant or nursing (circle): Pregnant/Nursing/None

Approximate date of last exam: _____

Reason for visiting today:

- ☐ Annual Examination
- ☐ Lost or broken glasses/Want new glasses
- ☐ Want contacts/Change eye color
- ☐ Blurred distance/Near vision
- ☐ Headaches/Fatigue

Other: _____

Patient Health History:

- ☐ **None apply**
- ☐ Glaucoma
- ☐ Cancer
- ☐ Diabetes
- ☐ Thyroid
- ☐ Retinal Disorder
- ☐ Macular Degeneration
- ☐ High Blood Pressure
- ☐ Heart Disease/Stroke
- ☐ Color Deficiency

Other: _____

I am aware the doctor may use dilating drops: Consent____ Decline ____ Signature: _____

By signing below, I am aware that today's visit will not be billed to my insurance, and I am responsible for any examination fees. I acknowledge that I have been offered a copy of the privacy notice. I authorize Family Optometric Associates, P.C. to disclose my health information as needed for continuity of care by my verbal consent. This may be revoked only by a written or electronic note.

Patient's signature (parent, if minor): x_____

Doctor: x_____ **Date:** _____

I have reviewed or updated my information from the previous date of service.

Signature: x_____ Date: _____

Signature: x_____ Date: _____

Signature: x_____ Date: _____

For office use only

DOS: CLE/RX Ins: CPT: Dx: Tech:

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Retinal Photography

At Family Optometric Associates, we pride ourselves in providing our patients with the best possible standard of eye-care. Retinal photography is a non invasive test that provides our doctors with a photo of your retina. This image becomes a permanent part of your medical file, allowing our doctors to make important comparisons year to year.

These images will help see early signs of many ocular and systemic diseases which can lead to partial or total loss of vision. Some condition often develop without warning and progress with no symptoms.

These conditions include, but are not limited to:

- Glaucoma
- Macular Degeneration
- Diabetes
- High Cholesterol
- Retinal Holes or Detachment

This Photography is an essential part of your eye exam.

THERE IS AN ADDITIONAL FEE OF $39.00 FOR THIS ADVANCED TEST.

☐ **YES, I would like** to have retinal photography done.

☐ **NO, I would NOT like** to have retinal photography done.

_____

Patient Name

_____ _____

Printed Name Signature Date