General Information

Today's Date:_____

Patient Name:_____

Date of Birth: _____

SSN#:_____

Birth Sex: M/F

Phone: _____

Address:_____

Email: _____

Employer/School: _____

How did you learn about our office?

_____

Reason for Visit: _____

Date of Last Eye Exam: _____

Primary Care Provider: _____

Do you currently wear glasses? ____ Yes ____ No
Do you currently wear contacts? ____Yes ____No

Please list any current issues with glasses or contacts:

_____

_____

Have you ever been diagnosed with or treated for:

____ Glaucoma
____ Cataract
____ Macular Degeneration.
____ Retinal hole/detachment
____ Eye Injury
____ Uveitis
____ Dry Eye
____ Eye turn/Lazy eye

Have you ever had eye surgery? ____Yes ____ No

If so, what kind? _____
Are you pregnant or nursing? Yes/No
Do you smoke? Yes/No Do you drink? Yes/No

Patient Medical Information

Please list **all medications** including eye drops, vitamins, supplements, and birth control. You may also just list your pharmacy so that we may pull your prescribed medicines from their records:

_____

_____

_____

_____

Please list any allergies to medications or list None:

_____

Have you ever been diagnosed with or treated for:

Constitution:
___Cancer

Ear/Nose/Throat:
___Hearing Loss
___Dry Mouth

Neurological:
___Multiple Sclerosis
___Migraine/Epilepsy
___Autism Spectrum Disorder

Psychological:
___Depression/Anxiety
___Attention Deficit

Cardiovascular:
___Arrythmia
___High Blood Pressure
___Heart/Vascular Disease

Respiratory:
___Asthma/COPD
___Sleep Apnea

Other: _____
_____

Gastrointestinal:
___Chron's/Colitis/Celiac
___GERD
___Ulcer

Genitourinary:
___ Kidney Disorder
___Prostate Disease

Muscular/Skeletal:
___Arthritis
___Fibromyalgia

Integumentary:
___Eczema/Rosacea
___Herpes Simplex
___Herpes Zoster

Endocrine:
___Diabetes
Type 1 or Type 2?
___Hypo/Hyperthyroid

Blood/Lymph:
___Anemia
___High Cholesterol

Allergy/Autoimmune:
___Environmental
___Lupus/Sjogren's/RA

Do you have any specific questions/concerns you would like addressed at this visit?

_____

**Please be advised if you are using insurance coverage for today's visit, this is a contract between you and your insurance company, NOT Sawyer Scott Eye Care Center.*

**If your insurance company has not reimbursed our office in full within 90 days, you will be responsible for full payment.*

**You authorize the release of information necessary to process your insurance claim and authorize payment to our office.*

**Your vision plan requests that all diagnoses related to any medical condition you may have be released to them. As a non-traditional disclosure, release of this information requires my specific authorization.*

Signature: _____ Date: _____

***If parent/guardian signing on behalf of minor*:**

***Signature:* _____ *Date:* _____**

***Relationship to minor:* _____**

I have had the opportunity to read and agree to the HIPAA Policies.

Signature: _____ Date: _____

I authorize any information pertaining to my medical records to be released to the following people:

Name_____
Relationship_____
Phone_____

Name_____
Relationship_____
Phone_____

Payment is required at time of service.

How will you settle your account balance today?

Cash Credit Check

CONTACT LENS PATIENT AGREEMENT

Please read below and sign at the bottom if you are a current contact lens wearer or are considering contact lenses. You must sign every year in order to receive a contact lens evaluation.

THE COMPREHENSIVE EYE EXAM

Before a person can be fit with contact lenses, a comprehensive eye examination is necessary. This exam is critical to assure the health of your eyes and to rule out any condition that may prevent contact lens use. **Contact lens prescriptions cannot be renewed without an annual exam**.

Corneal Evaluation

Contact lenses are medical devices that require ongoing evaluation to ensure safe and comfortable wear. This evaluation is necessary and is in addition to your comprehensive exam and includes:

- Evaluation of current or new lenses on the eye
- Evaluation of cornea, conjunctiva, and eyelid health related to contact lens wear
- Progress checks related to contact lens prescription and fit

This exam requires an additional fee that may or may not be covered by insurance

CONTACT LENS TRAINING SESSION

For first time wearers the patient will be provided with personalized instruction concerning the safe care and usage of contact lenses. Upon completion of successful insertion and removal, the patient may begin wearing the contact lenses and we will schedule a follow-up appointment in a week if needed.

There is no charge for follow-up visits during the first 60 days. After that we will be glad to see you for a $70 office visit.

I have read and agree to the above:

Signature: _____