Special-Eyes Vision Center

Please Print

PATIENT INFORMATION Date:____________________

NAME (Last, First, Mi) ____

DATE OF BIRTH__________________________AGE_______ SS#________________________

ADDRESS____

CITY___________________________________ STATE _______ ZIP CODE_________________

PHONE HOME[ ] _________________CELL[ ]______________WORK[ ] ________________

Please check box next to best number to call.

EMAIL____OCCUPATION_____________________

EMPLOYER ______________________________ REFERRED BY__________________________

INSURANCE INFORMATION (Tricare patients MUST disclose any other health insurance)

Primary Medical Insurance:

Insurance company name: ____

Sponsor's name:____

Sponsor's ID# _________________________________ Sponsor's DOB: ________________

Secondary Medical Insurance:

Insurance name: ________________________

Sponsor's name:________________________

Sponsor's ID#__________________________

Vision Insurance:

Insurance name: _______________________

Sponsor's name:_______________________

Sponsor's ID#_________________________

EMERGENCY INFORMATION

In case of emergency please notify____

Phone #____________________________ Relationship to patient: _____________________

FINANCIAL RESPONSIBILITY

I permit a copy of this authorization to be used in place of the original, and request payment of insurance benefits to Dr. Jennifer Goette. I understand and accept financial responsibility for all and any services rendered to me. I understand my insurance is billed as a courtesy to me and payment of any bills are my responsibility.

PATIENT/GUARDIAN SIGNATURE________________________ DATE: ____________

NOTICE OF PRIVACY PRACTICES

A "Notice of Privacy Practices" that describes how my protected health information is used/disclosed has been made available to me. I understand that I may request a printed copy at any time.

PATIENT/GUARDIAN INITIALS ___________________________ DATE: ____________

Medical History and Review of Systems **Special-Eyes Vision Center**

Patient Name ____________________________________**Date**____________________

Family History

Please answer the questions below regarding your **immediate** family (parents, grandparents, siblings, children). For all "YES" answers, please specify family member. (mgm/mgf = maternal grandmother/father) (pgm/pgf = paternal grandmother/father)

Blindness	Yes/No_____________	Diabetes	Yes/No
Crossed or Lazy Eye	Yes/No____________	Hypertension	Yes/No__________
Cataracts	Yes/No____________	Heart Disease	Yes/No__________
Glaucoma	Yes/No____________	Thyroid Disease	Yes/No__________
Macular Degeneration	Yes/No____________	Cancer	Yes/No__________
Retinal Detachment	Yes/No____________	Lupus	Yes/No__________
Other Eye Disease______________________		Other	_________________________

Patient Ocular and Medical History/Review of Systems

Please check if you are currently having any problems in the following areas:

Eyes		**Ears, Nose, Throat**	
Cataracts	______	Sinusitis	______
Glaucoma	______	Hearing loss	______
Macular Degeneration	______	**Endocrine**	
Retinal Detachment	______	Diabetes	______
Eye injury	______	Thyroid	______
Lazy Eye	______	Pituitary Disorder	______
Blurred vision	______	Crohn's Disease	______
Crossed eye	______	**Vascular/Cardiovascular**	
Halos around lights	______	Vascular disease	______
Loss of side vision	______	High Blood Pressure	______
Double vision	______	High Cholesterol	______
Dryness	______	Heart disease	______
Mucous discharge	______	Stroke	______
Redness	______	**Gastrointestinal**	
Sandy/gritty feeling	______	Acid Reflux	______
Itching	______	Hepatitis	______
Burning	______	**Genitourinary**	
Light sensitivity	______	Kidney/bladder	______
Eye pain or soreness	______	**Bones/Joints/Muscles**	
Flashes/ Floaters	______	Marfan's Syndrome	______
Redness	______	Rheumatoid arthritis	______
Constitutional		Anklyosing Spondylitis	______
Fever	______	**Lymphatic/Hematologic**	
Weight changes	______	Sickle Cell	______
		Anemia	______

Integumentary(skin)		**Respiratory**	
Rosacea	_______	Asthma	_______
Skin cancer	_______	Emphysema	_______
Neurological		**Psychiatric**	
Headaches	_______	Depression	_______
Migraines	_______	Anxiety	_______
Seizures	_______	ADD/ADHD	_______
Bell's Palsy	_______	Autism	_______
Multiple Sclerosis	_______	**Allergic/Immunological**	
Brain tumor	_______	Lupus	_______
Nystagmus	_______	AIDS/HIV	_______
Myasthenia Gravis	_______	Sjorgren's Syndrome	_______

Others disorders not listed above: ____

Primary Care Physician____

Please list all major injuries, surgeries and hospitalizations:_________________________
____
____

Please list any prescription and non-prescription medications:_______________________
____
____

Allergies to medications____
____

Have you had eye surgery? Yes/No If yes, what kind? Lasik/ PRK/ RK/ Cataract

Do you wear glasses? Yes/No Do you wear contact lenses? Yes/No
Is this a contact lens exam? Yes/No Have you worn contacts in the past? Yes/No

Females: Are you pregnant or nursing? Yes/No If yes, which? ___________________

Social History

Do you smoke?	Yes/No	If yes, how many packs/ per day?________________
Do you use alcohol?	Yes/No	If yes, how often?______________________________
History of STD?	Yes/No	Do you use recreational drugs? _________________

Reason for today's visit____

Patient signature____________________________________Date_____________________

Reviewed on: Date______Initials_______Date______Initials_______Date______Initials_______________

Digital Retinal Photography

Retinal photography is done with a highly sophisticated computerized camera that takes photographs of the back of the eye (the retina), and enables us to carry out a far more detailed examination. The procedure is comfortable, the image is captured in seconds and nothing touches your eye. The benefits of retinal photography are:

- A permanent and accurate record can be kept of the retina. Each person's retina is unique and should look the same throughout your life.
- Improved early detection of retinal changes by comparing images each year.
- Enhances the way we check your retinas to insure their health.
- Retinal photography allows you to see what we see when we examine your eyes and understand any changes taking place.

There is an additional $20.00 charge for this test. Please check the appropriate line.

______I DO want retinal photography.   _______ I do NOT want retinal photography.

Scanning Computerized Diagnostic Imaging (GDX)

GDX imaging is the newest way to detect glaucoma. It can detect even the smallest amount of damage to the optic nerve so treatment can begin at once to prevent vision loss. Glaucoma is a "silent" disease whose diagnosis can be challenging. Having a GDX scan can help determine if there is any damage to the optic nerve earlier than any other method available. The GDX scan is a non-invasive test that takes only a few minutes and the results are immediate. This test is especially recommended for individuals with:

- A family history of glaucoma.
- Diabetic patients.
- Patients with high blood pressure.
- African Americans over the age of 50.

There is an additional $30.00 charge for this test. Please check the appropriate line.

______I **DO** want the imaging test.   ______I **DO NOT** want the imaging test.

Patient Signature ______________________________   Date ________________________