Consent for Examination and Treatment

Patient Name_____: In seeking appropriate and medically necessary eye care services, I voluntarily consent to such care including routine diagnostic and therapeutic procedures and medical treatment to be provided by the office of Eyespecs Vision Care. I acknowledge that no guarantees have been made to me as to the results of treatments or examinations in this office. This consent has been fully explained to me and I certify that I understand its contents. I authorize the Eyespecs Vision Care to retain images or clinical information from the examination or treatment consistent with HIPAA regulations for patient privacy protection.

_____

Signature of Patient / Date

If relative or legal guardian signs, indicate relationship:_____

Acknowledgement of Receipt of Notice of Privacy Practices

My signature below verifies that I have been informed and provided a copy of the Notice of Privacy Practices which details how certain health information about me may be used and disclosed by Eyespecs Vision Care and how I may obtain access to and control this information.

Signature: _____ Date: _____

Signature of Patient Representative _____ Date: _____

Relationship to Patient: _____

Welcome to EyeSpecs Vision Care

Today's Date _____

Name *(last)*_____*(first)*_____*(middle initial)*_____

Street Address_____ Home Phone _____

City/State/Zip Code_____ Work Phone _____

Guardian (if applicable)_____ Cell Phone _____

Birth Date_____ E-mail address _____

Preferred method to contact you: E-mail_____ Text_____ Cell Phone_____

How did you learn about our office? ____ Our office website ____ Another patient ____ Yelp
____ Insurance website ____ Another doctor ____ Advertisement

When was your last eye examination? *(if known)*_____

Previous eye doctor *(if known)*: _____

Occupation: _____ Employer: _____

Vision Care Insurance:_____ Primary Medical Insurance: _____

Primary Care Physician:_____

What is the main reason for your visit?_____

Do you wear glasses?_____ Are you interested in glasses today?_____

Do you wear contact lenses?_____ Are you interested in contact lenses today?_____

If contact lenses wearer: CL Brand:_____

CL Rx *(if known)*: Right Eye:_____ Left Eye: _____

Past, Family and/or Social History

Is there anything in your past history, family history or social history which would help us care for you?

● Past History (illnesses, operations, injuries, medications, treatments) Y____ N ____

If yes, please explain: _____

● Family History (diseases, hereditary, risk factors, glaucoma) Y ____ N ____

If yes, please explain: _____

● Social History (past and current activities)

Do you use any of the following products: Tobacco Y ____ N ____
Alcohol Y ____ N ____
Recreational Drugs Y ____ N ____

Review of Systems: Do you have a problem with …

Eyes	Y__ N__	**Allergic/Immunologic**		**Hematologic/Lymphatic**	
Blindness	Y__ N__	HIV	Y__ N__	Anemia	Y__ N__
Loss of vision	Y__N__	Hay fever	Y__ N__	Bleeding problems	Y__ N__
Distorted vision	Y__ N__	Medicine allergies	Y__ N__	Swelling	Y__ N__
Blurred vision	Y__ N__	**Constitutional Symptoms**		**Integumentary** (skin)	
Double vision	Y__ N__	Fever, Weight loss/gain	Y__ N__	Skin Disease/Cancer	Y__ N__
Cataracts	Y__ N__	**Cardiovascular**		Herpes Zoster/Shingles	Y__ N__
Crossed eyes	Y__ N__	High Cholesterol	Y__ N__	**Musculoskeletal**	
Flashes or floaters	Y__ N__	Heart pain	Y__ N__	Arthritis	Y__ N__
Dry eyes	Y__ N__	High blood pressure	Y__ N__	Rheumatoid arthritis	Y__ N__
Watery eyes	Y__ N__	Vascular disease	Y__ N__	Muscle/Joint pain	Y__ N__
Red eyes	Y__ N__	**Ears, Nose, Mouth, Throat**		**Neurological**	
Mucous discharge	Y__ N__	Sinus problems	Y__ N__	Multiple Sclerosis	Y__ N__
Burning or itching	Y__ N__	Chronic cough	Y__ N__	Headaches	Y__ N__
Sandy or gritty feeling	Y__ N__	Dry throat/mouth	Y__ N__	Migraines	Y__ N__
Eye pain or soreness	Y__ N__	Chronic ear infections	Y__ N__	Seizures	Y__ N__
Glare/light sensitivity	Y__ N__	**Endocrine**		**Psychiatric**	
Chronic eye infections	Y__ N__	Diabetes	Y__ N__	Nervous disorders	Y__ N__
Tired eyes	Y__ N__	Thyroid problems	Y__ N__	Depression	Y__ N__
Halos	Y__ N__	Other glands	Y__ N__	**Respiratory**	
Vision therapy	Y__ N__	**Gastrointestinal**		Sleep Apnea	Y__ N__
Age-Rel Macular Deg	Y__ N__	Ulcers	Y__ N__	Asthma	Y__ N__
Eye injury	Y__ N__	Constipation	Y__ N__	Shortness of breath	Y__ N__
Retinal detachment	Y__ N__	**Genitourinary**		Emphysema	Y__ N__
Glaucoma	Y__ N__	Genitals/kidneys/bladder	Y__ N__	Lung cancer	Y__ N__

Please list all medications and any additional pertinent information:

_____