Buenau's Opticians Inc

Identifying Information

Last Name______________________________First Name_______________________________________MI_______________
Address______________________________________City_________________________State________Zip_______________
Home Phone_______________________________Work Phone_____________________________Date of Birth_____________
Occupation_____________________________Employer______________________________SS#__________________________
Parent/Gaurdian______________________________Emergency Contact and Phone_____________________________________
Email Address ____

Patient Eye History

What is the major purpose of this visit?____
Date of Last Eye Exam / /
Do you currently wear contact lenses? □ Yes □ No What brand of contacts do you wear? _______________________
Are you interested in contact lenses today? □Yes □ No Are you interested in LASIK? □Yes □No □Maybe

Have you ever been diagnosed or treated for the following?

Condition	
Cataracts	□ Yes □ No
Glaucoma	□ Yes □ No
Macular Degeneration	□ Yes □ No
Retinal Detachment	□ Yes □ No
Lazy eye or Eye turn	□ Yes □ No
Eye Injury	□ Yes □ No
Eye Surgery	□ Yes □ No

Do you experience any of the following?

Symptom	
Blurry Vision	□ Yes □ No
Headaches	□ Yes □ No
Double Vision	□ Yes □ No
Flashes of Light	□ Yes □ No
Persistent Floaters	□ Yes □ No
Eye Itching	□ Yes □ No
Eye Burning	□ Yes □ No
Eye Tearing	□ Yes □ No

Patient Medical History, Review of Systems, Social History

Name of Family Physician ____ Telephone _________________________________
Please list any Allergies to Medications □None ____
Please list any Medications or Vitamins that you are currently taking □None ____________________________________
____
Have you ever been diagnosed or treated for any of the following problems?

			Explanation of Problem
Endocrine- thyroid, hormones, glands	□ Yes	□ No	______________________________
Cardiovascular – heart, blood vessels	□ Yes	□ No	______________________________
High Blood Pressure	□ Yes	□ No	______________________________
Respiratory- lungs, breathing	□ Yes	□ No	______________________________
Gastrointestinal- stomach/ intestines	□ Yes	□ No	______________________________
Genitourinary- genitals, kidneys, bladder	□ Yes	□ No	______________________________
Musculoskeletal- muscles, joints, arthritis	□ Yes	□ No	______________________________
Integument- skin	□ Yes	□ No	______________________________
Neurological- migraine, seizures	□ Yes	□ No	______________________________
Psychiatric	□ Yes	□ No	______________________________
Ears, Nose, Mouth or Throat	□ Yes	□ No	______________________________
Hematologic/Lymphatic- anemia, bleeding	□ Yes	□ No	______________________________
Allergic/ Immunologic	□ Yes	□ No	______________________________
HIV/AIDS	□ Yes	□ No	______________________________

Do you have Diabetes? □Yes □No What year were you diagnosed?______Type 1□ or 2□ ? What was your last HbA1c? ______

Do you use tobacco products? □Yes □No If yes, type/amount/how long?____
Do you drink alcoholic beverages? □Yes □No If Yes, type/amount/how long?____
Are you currently Pregnant or Nursing? □Yes □No

Please list any other medical conditions you have that are not listed above____
____

Please turn this form over and complete side two

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Family History

Is there any family medical history of any of the following? (**If yes please list the relationship to you**)

Cataracts	□Yes □No	_______________	Diabetes	□Yes □No	___________________
Glaucoma	□Yes □No	_______________	High Blood Pressure	□Yes □No	___________________
Lazy Eye	□Yes □No	_______________	Retinal Detachment	□Yes □No	___________________
Macular Degeneration	□Yes □No	_______________	Color Blindness or other	□Yes □No	___________________

Patient Insurance Information

Vision Insurance Carrier___________________________
ID #____
Policy Holder's Name______________________________
Policy Holder's DOB_______________________________

Medical Insurance Carrier_________________________
ID #____
Policy Holder's Name_____________________________
Policy Holder's DOB______________________________

Contact Lens Medical Management

For your health and safety, we perform annual contact lens evaluations. A separate contact lens fee is charged beyond the comprehensive eye examination. We determine fit, health and condition of the eyes with contact lenses. We also evaluate changes in prescription and lens design during this process. Fees start at $60 for a new contact lens wearer and start at $30 for a current contact lens wearer.

Authorization to pay benefits to physician.

I hereby authorize payment directly to the doctor for benefits to ME for services received. I understand that I am responcible for the balance of fees not paid by the insurance.

I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF BUENAU'S OPTICIANS NOTICE OF PRIVACY PRACTICES.

Please sign below that you have reviewed all of the information above and on the reverse side and it is correct to the best of your knowledge.

Signature_______________________________________ ***Date***_________________________________

Signature_______________________________________ ***Date***_________________________________

Signature_______________________________________ ***Date***_________________________________

Signature_______________________________________ ***Date***_________________________________

*****For office use only below this line*****

Doctor's Signature___________________________________ Date_____________________________________

Date Updated					
Doctor's Initials					

Visual Field Examination

A visual field examination determines to what degree you are able to see peripheral objects while fixated on a stationary object. If a reduction of this ability is shown, it could be an indication of many disorders, including glaucoma, brain tumors, diabetic retinopathy, and retinal detachment.

Using a new computerized instrument, we are now able to provide a more thorough medical analysis of your eyes, not able to be provided through a routine examination. Our Humphrey FDT electronically measures retinal function and sensitivity to light, to aid in the diagnosis of these very serious diseases. There is currently no better method of early detection and therefore early treatment.

We strongly recommend that all our patients receive the screening version of this test. It is especially important for people who:

- Experience frequent **headaches**
- Have a history of **glaucoma** in their family
- Are a stroke candidate and/or had a **stroke**
- See **spots** or **flashes** of light
- Have a history of **diabetes**
- Have a history of **high blood pressure**
- Require a **strong eyeglasses prescription**
- Require a **frequent change** in their prescription
- Are 35 years of age or older

There is an additional charge of $10 for the screening exam. A receipt will be given to you for submission to your insurance company.

Please check the appropriate line below, and sign at the bottom.

❑ **I DO** want the Visual Field Exam.

❑ **I DO NOT** want the Visual Field Exam.

Patient's Signature ______________________ Date ____________