Desert Family Eye Care
Reed Family Vision Center
Patient Form

Legal Name: ______________________________
Nickname: ______________________________
Address: ______________________________
City: ______________ State: ______ Zip: ________
Home phone: ______________________________
Cell phone: ______________________________
Email: ______________________________
Patient Social Security Number: ____ - ____ - _______
Date of Birth: _____ / _____ / ________ Gender: M / F
Occupation: ______________________________
Employer: ______________________________
Emergency Contact Person: ______________________
Phone Number: ______________________________
Primary Care Physician: _________________________
Phone Number: ______________________________
Vision Insurance: __________________________
Member ID Number: __________________________
Group Number: ______________________________
Primary Cardholder Name: _____________________
Primary Cardholder DOB: ______________________
Medical Insurance: __________________________
Member ID Number: __________________________
Group Number: ______________________________
Primary Cardholder Name: _____________________
Primary Cardholder DOB: ______________________

Current Medications: __________________________
____
____
____
____
____
____

Allergies to medications: _______________________
____
____

Do you use cigarettes or tobacco? Yes / No
Are you pregnant? Yes / No
Are you nursing? Yes / No
Reason for today's visit: _________________________
____
How did you hear about us? ______________________
Date of last eye exam: ___________________________
Currently wear glasses? Yes / No
Currently wear contacts? Yes / No
If yes, how often do you replace your contacts? ______
Interested in obtaining contacts? Yes / No

Have you ever had any of the following conditions involving your eyes?

Poor Distance Vision:	Yes / No	**Watering:**	Yes / No
Poor Near Vision:	Yes / No	**Dry Eyes:**	Yes / No
Flashes of Light:	Yes / No	**Headaches:**	Yes / No
Floaters / Spots:	Yes / No	**Eye Surgery:**	Yes / No
Light Sensitivity:	Yes / No	**Burning:**	Yes / No
Eye Strain:	Yes / No	**Itching:**	Yes / No
Double Vision:	Yes / No	**Eye Injury:**	Yes / No
Eye Infection:	Yes / No	**Loss of Vision:**	Yes / No

Do you or anyone in your immediate family have a history of the following? Please circle all that apply:

Glaucoma:	Self	Family	N/A
Cataracts:	Self	Family	N/A
Retinal Disease:	Self	Family	N/A
Turned or lazy eye:	Self	Family	N/A
Blindness:	Self	Family	N/A
High blood pressure:	Self	Family	N/A
Thyroid disease:	Self	Family	N/A
Heart Condition:	Self	Family	N/A
Arthritis:	Self	Family	N/A
Diabetes:	Self	Family	N/A
Respiratory Problems:	Self	Family	N/A
Cancer:	Self	Family	N/A

Dilation Consent:
Since our office is committed to the prevention of disease, we recommend dilation of the eyes as part of every examination. Dilation is the use of drops to temporarily enlarge the pupils, which allows the doctor to fully examine the retina and inner eye. Dilation is recommended for all new patients, people with a history of headaches, diabetes, high blood pressure, high cholesterol, glaucoma, high prescriptions, and past eye problems. Most people experience an increased sensitivity to light and decreased near vision for up to 6 hours after dilation. Driving is usually not impaired, but may require extra attention.

_____ **YES** – I give consent for my eyes to be dilated today.
_____ **NO –** I decline having my eyes dilated today. I understand the importance of dilation, and release Reed Family Vision Center for any liability related to the failure to detect and treat any condition in which the diagnosis would have been aided by the completion of dilation.
Initials: _______

I understand and agree that regardless of my insurance status, I am responsible for the balance on my account for any services rendered. I certify the above information is correct. I understand updates of my personal information are needed for quality care.
I do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.
Sign: ______________________________________
Date:______________________