Desert Family Eye Care
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 Desert Family Eye Care 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: _____

Contact Lens wearers: I understand that there is a contact lens evaluation and management fee charged every year to ensure optimal contact lens care. **Sign:**_____

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:_____