BRILLIANT EYE CARE

PLEASE PRINT (write as legible as possible and **fill out every question**)

Name: _____ Date of Birth: _____/_____/_____ Date:_____

Address: _____

City: _____ State: _____ Zip Code: _____Phone Number: _____

E-mail Address: _____Occupation: _____Employer: _____

LAST Eye Exam: _____Doctor: _____LAST Medical Exam: _____Doctor: _____

Medical Insurance _____ Vision Insurance _____

PAST OCULAR HISTORY: (Please check if you ever had any of the following)

___ Eye Infection ___ Eye Injury ___ Lazy Eye ____ Dry Eye ___ Cataract ___ Glaucoma ___ Macular Degeneration

___ Eye Surgery ___ Other: _____

PAST MEDICAL HISTORY: (Please check if you have or ever had any of the following)

___ Hypertension ___ Respiratory Problem ___ Thyroid Problem ___ GI problem ___ Bone/Joint Problem

___ Diabetes ___ Other: _____

If diabetic, are you type 1 or type 2: _____What year were you diagnosed: _____ What is your Hemoglobin A1c:____%_

Are you allergic to anything (including medications)? □ No. □ Yes. Please list: _____

_____

Are you taking any medications? □ No. □ Yes. Please list: _____

_____

List all major injuries, surgeries, or hospitalizations: _____

_____

Are you pregnant and/or nursing? □ No. □ Yes. How many weeks pregnant:_____

Do you use tobacco products? □ No. □ Yes. Type/Amount/How long: _____

Do you drink alcohol? □ No. □ Yes. Type/Amount/How often: _____

Do you use recreational drugs? □ No. □ Yes. Type/Amount/How often: _____

FAMILY HISTORY: (Please note any family history including parents, grandparents, siblings, children; living or deceased)

CONDITION	NO	YES	RELATIONSHIP	CONDITION	NO	YES	RELATIONSHIP
Blindness	□	□	_____	Diabetes	□	□	_____
Glaucoma	□	□	_____	Hypertension	□	□	_____
Macular Degeneration	□	□	_____	Heart Disease	□	□	_____
Retinal Detachment	□	□	_____	Cancer (type?)	□	□	_____
Retinal Disease	□	□	_____	Other: _____			_____

DILATION OF THE EYE

When the eyes are dilated, the doctor is able to get a broader view of the inside of the eyes. If you are experiencing any **floaters or flashes of light**, a dilated examination is **required** to determine the cause. Dilation is recommended for all patients regardless of age. The side effects of dilation include blurred vision at near (approximately 4-6 hours or longer) and sensitivity to light. The distance vision may also be blurred in some individuals. There is no additional charge for the dilation.

VISUAL FIELD TESTING

A visual field analyzer checks for loss of sight or missing areas of vision, both centrally and peripherally. It is possible to map the health of the nerve pathway by this method. Visual field testing can assist us in the detection of glaucoma, retinal problems (such as diabetic retinopathy, tears, holes, and detachments) and some neurological diseases. This is a non-invasive, painless test that takes approximately 5 minutes for an additional fee of **$15**. Medical insurance **may** cover this test depending on your policy and/or diagnosis.

(Initials)_____ **Yes**, I do want to have a visual field screening today.

(Initials)_____ **No**, I do not want to have a visual field screening at this time. I do not hold Brilliant Eye Care and its employees liable for eye diseases which could have been detected by the visual field screening.

iWELLNESS SCAN

The Topcon Maestro OCT camera gives a 3D image of the retina. It is a quick, painless, and comprehensive scan used for early detection, monitoring, and treatment of eye diseases such as **Diabetes, Glaucoma, Macular Degeneration, and Retinal Detachments**. Since these diseases tend to progress without any symptoms in the early stages and can lead to blindness, the iWellness scan is highly recommended for all patients. The fee for the wellness scan is **$25**. Medical insurance **may** cover this test depending on your policy and/or diagnosis.

(Initials)_____ **Yes**, I do want to have **iWellness scan** done today**.**

(Initials)_____ **No**, I do not want to have **iWellness scan** done at this time. I do not hold Brilliant Eye Care and its employees liable for eye diseases which could have been detected by the iWellness scan.

RETINAL IMAGING

Hate getting Dilated? We can save you time and blurred vision with the Optomap Daytona, a ultra-widefield retinal imaging system that uses the newest scanning laser technology to provide a high resolution 200 degree view **without the side effects of dilation drops.** Optomap imaging can help detect abnormalities in the eye that can lead to blindness and takes less than a minute to capture. It is highly recommended for all since it is a permanent record used to compare for potential retinal changes. The fee for the Optomap image is only **$35**. Medical insurance **may** cover this test depending on your policy and/or diagnosis.

(Initials)_____ **Yes**, I do want to have **Optomap** imaging done today**.**

(Initials)_____ **No**, I do not want to have **Optomap** imaging done at this time. I do not hold Brilliant Eye Care and its employees liable for eye diseases which could have been detected by Optomap imaging.

GENERAL ACKNOWLEDGEMENTS

1. I have read and understand Brilliant Eye Care's Notice of Privacy Practices Form.
2. I also understand that I have 60 days to return to the clinic with any concerns regarding my prescription at no charge. Any visits after the 60-day period may be subject to an additional examination fee due to possible changes in vision.
3. I understand insurance may cover none or only part of my fees. If my insurance does not pay as expected, I am ultimately responsible for all charges for services rendered to me on this day. I do not hold Brilliant Eye Care and its employees responsible if I am not eligible for benefits at the time of my visit.

_____ _____

Patient Signature (or Guardian's Signature) Date