

“We are here to meet your needs and wants.
Please fill out this information so we may best improve your life.” - Dr. Tate

PATIENT INFORMATION SHEET

Patient Name: _____ Nickname: _____ DOB: _____ Gender: M / F

Address: _____ City: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____

SSN: _____ Email Address: _____

Occupation: _____ Employed by: _____

Marital Status: Single Divorced Widowed Married Spouse's Name: _____

Race: White Hispanic Asian African American American Indian Other: _____

Ethnicity: Not Hispanic or Latino Hispanic or Latino

Communication Preference: Phone Texting Email May we text for apt reminders? Yes No

Parent/Guardian Name (if applicable): _____ Parent/Guardian DOB: _____

Emergency Contact: _____ Emergency Phone Number: _____

Medical Insurance: Please provide us with a copy of your card(s) to keep on file.

Vision Plan: _____ Policy Holder's Name: _____ DOB: _____

Medicare and Other Medical Insurances

I understand that Insight Eyecare may bill my medical insurance if my exam is not a routine vision exam. I understand that Insight Eyecare is contracted to follow my insurance's billing rules. That may include charging a copay for each visit and that the entire balance of the visit may get applied towards my deductible (which the patient is responsible for) if my insurance plan deems proper.

HIPAA

I agree to and understand that this clinic complies with all requirements of HIPAA, my rights to my records and privacy. I understand that there are full copies of the HIPAA statement available at the front desk and waiting room.

I agree to and understand the policy summaries. I understand that full length copies are available and are posted.

Signed Patient (or Parent/Guardian): _____ Date: _____

If you would like to authorize us to share your records with anyone such as family or a guardian, list their names below:

Spouse My Children My Parents Other: _____

For new patients, how did you hear about us?

Drive by Google Our website Vision Plan Referred by: _____

MEDICAL HISTORY QUESTIONNAIRE

This questionnaire is designed to speed up your visit today. All questions are either pertinent to the health of your eyes or are legally required. Thank you for your cooperation!

Primary Care Physician: _____

Medical History

Eyes	Yes	No		Yes	No
Recent Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	Sudden Changes to Vision	<input type="checkbox"/>	<input type="checkbox"/>
Itching, Burning, or Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Glare, Light Sensitivity, or Halos	<input type="checkbox"/>	<input type="checkbox"/>
Eye Pain or Soreness	<input type="checkbox"/>	<input type="checkbox"/>	Dry Eye or Fluctuating Vision	<input type="checkbox"/>	<input type="checkbox"/>
Eye Injury or Other Eye Disease	<input type="checkbox"/>	<input type="checkbox"/>	History of Crossed or Lazy Eye	<input type="checkbox"/>	<input type="checkbox"/>
Suffered 2 or more Concussions?	<input type="checkbox"/>	<input type="checkbox"/>	Difficulties in School	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had prism in your glasses?				<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been suspected of having or have glaucoma?				<input type="checkbox"/>	<input type="checkbox"/>
Headaches or Blurry Vision at the end of the day?				<input type="checkbox"/>	<input type="checkbox"/>

Current or Previous Medical Problems

Ears, Nose, Mouth, Throat	<input type="checkbox"/>	<input type="checkbox"/>	Cardiovascular (Heart, Blood)	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory (Lungs, Breathing)	<input type="checkbox"/>	<input type="checkbox"/>	Digestive (Stomach, Intestines)	<input type="checkbox"/>	<input type="checkbox"/>
Genitourinary (Kidney, Bladder)	<input type="checkbox"/>	<input type="checkbox"/>	Musculoskeletal (Muscles, Joints)	<input type="checkbox"/>	<input type="checkbox"/>
Integument (Skin, Breast)	<input type="checkbox"/>	<input type="checkbox"/>	Neurological	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>	Endocrine (Hormones, Glands)	<input type="checkbox"/>	<input type="checkbox"/>
Immune Syst. (Blood, Arthritis)	<input type="checkbox"/>	<input type="checkbox"/>	Seasonal Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Cancer /Tumors	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes (Anytime or Borderline)	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>
Do you have High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Are you Pregnant?	<input type="checkbox"/>	<input type="checkbox"/>

Any other Medical Problems or Conditions: _____

Please List any Eye drops Recently Used: _____

List any Surgical Procedures to the Eyes or Body: _____

List any Medications that you are Currently Using or Provide a Preprinted List: _____

Please List all Allergies to Medications: None _____

OCULAR Family History	Yes	No		Yes	No
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	Retinal Detachment	<input type="checkbox"/>	<input type="checkbox"/>

If yes, what family member: _____

MEDICAL Family History (siblings, parents, or grandparents)

Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis, Lupus, etc.	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	If yes, what family member:	_____	

Social- Government required questions:

Do you drink alcohol? Never Less than 10 drinks/week Greater than 10 drinks/week
 Do you use tobacco? Yes No How often per day (tobacco)? _____

Preferred Pharmacy: _____ None

OCULAR

	Yes	No		Yes	No
Have you ever worn glasses before?	<input type="checkbox"/>	<input type="checkbox"/>	Do you like wearing them?	<input type="checkbox"/>	<input type="checkbox"/>
How old are your most recent glasses?	_____years		Are you interested Lasik info?	<input type="checkbox"/>	<input type="checkbox"/>
Are you interested in new glasses if helpful?	<input type="checkbox"/>	<input type="checkbox"/>			

Contacts

Are you interested in wearing contacts?	<input type="checkbox"/>	<input type="checkbox"/>	Have you worn contacts before?	<input type="checkbox"/>	<input type="checkbox"/>
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Contact lenses require additional examination and follow ups. A **contact lens examination fee** is required which covers the additional time and any follow up visits to fit the contacts. Our contact lens fittings start at \$60 and depend on the difficulty of the fit. Please refer to front desk for any pricing questions.

Are you interested in your main glasses transitioning into sunglasses? Yes No

Do you get glare while driving with your glasses or contacts? Yes No Only at night

How many hours a day do you use a Computer/Tablet/Reader/Cell Phone: Less than 2 2 – 8 More than 8

Do you look at multiple computer screens at one time? Yes No

After using a computer or electronic device while wearing glasses or contacts, do your eyes seem tired? Yes No

Digital Eye Scan

“I want all of my patients to have our disease scan, including kids. It can find diseases earlier than a photo or my microscope. It allows us to detect disease years before vision is affected, meaning we can prevent vision loss before it starts.” Dr. Tate.

- A lasting record of the health of the eyes today to refer back to.
- A digital image of the inside of the eye and a safe scan of the macula and optic nerve.
- Your doctor will review and explain the results with you.

Without the eye disease scan, you may be limiting the ability to determine the health of the eye, unless you are scheduled to see Dr. Tate for a Dilated Medical exam. We use mild dilation on all complete, yearly exams.

This is highly recommended if you have glaucoma or macular degeneration in your family. Unless you have already been diagnosed with an eye disease, insurance does not pay for advanced tests like the disease scan. The additional fee is \$25. This is not paid by any insurance.

Yes, I would like the scan No, I do not want my eyes scanned

By signing below, I confirm that these records are full and accurate to the best of my knowledge.

Signed Patient (or Parent/Guardian): _____ Date: _____

Prayer Request (optional): _____

Verbal prayer in exam Silent prayer