WELCOME TO EYEDEAL VISION!

□ Dr. □ Mr. □ Mrs. □ Ms. _____

Last Name First Middle Initial

Birthdate _____/_____/_____ Sex □ M □ F Age _____ Occupation _____

Address _____ _____ _____ _____

Street Address City State Zip Code

Cell Phone _____ Home Phone _____ Work Phone _____

Who should we thank for referring you? □ Insurance List □ Wal-Mart □ Patient _____ □ Dr _____

EYE HEALTH HISTORY

Last eye exam (mo/yr): _____ Eye Doctor's Name: _____ Hours on computer daily: _____

Do you wear glasses? □ No □ Yes -------> When:□ Full time □ Rarely □ Read □ Drive □ TV □ Arts & craf □ Hunt □ _____

Do you wear contact lenses? □ No □ Yes ------> CL Brand: □ Acuvue □ Air Optix □ Biofinity □ Ultra □ _____

Overnight wear? □ No □ Rarely □ Yes -------> Dispose: □ Daily □ 2 weeks □ 1 month □ When lenses feel uncomfortable □ _____

If you've never worn contacts, are you interested in trying them today? □ No □ Yes------> □ Color Contacts □ Bifocal Contacts □ Astigmatism Lenses

What is the purpose of your visit today? □ Check Up/ Glasses □ Contact Lenses □ Both □ First Eye Exam Ever □ Other:_____

MEDICAL HEALTH HISTORY

Last physical exam (mo/yr): _____ Physician's Name: _____

Are you: □ Pregnant □ Nursing Do you: □ Smoke □ Drink alcohol; Amount: _____

Please indicate if **you** or a **blood relative** currently have, or have ever been treated for problems in the following areas:

	SELF		FAMILY
Eye Health:	**Yes**	**No**	**Who**
Cataracts (cloudy lens)	□	□	□
Glaucoma	□	□	□
Crossed/ Turned Eyes	□	□	□
Lazy Eye	□	□	□
Poor Color Vision	□	□	□
Macular Degeneration	□	□	□
Retinal Detachment	□	□	□
Temporary Vision Loss	□	□	
Blurry Vision - Far	□	□	
Blurry Vision - Near	□	□	
Burning/ Stinging Eyes	□	□	
Distorted Vision (halos)	□	□	
Double Vision	□	□	
Dry Eyes	□	□	
Eye or Lid Infection	□	□	

	SELF		FAMILY
	Yes	**No**	**Who**
Eye Injury	□	□	
Eye Pain/ Soreness	□	□	
Eye Strain/ Tired Eyes	□	□	
Eye Surgery: _____	□	□	
Flashes/ Floaters in Visior	□	□	
Itchy Eyes	□	□	
Light Sensitivity/ Glare	□	□	
Poor Night Vision	□	□	
Sandy or Gritty Eyes	□	□	
Twitching Eyelid	□	□	
Watery, Teary Eyes	□	□	
Medical Health:			
Asthma/ Bronchitis	□	□	□
Integumentary (Skin)	□	□	□
Diabetes	□	□	□

	SELF		FAMILY
	Yes	**No**	**Who**
High Blood Pressure	□	□	□
Cardiovascular/Heart	□	□	□
Genital/Kidney/Bladde	□	□	□
Joint/Muscle (arthritis)	□	□	□
Headaches/Migraines	□	□	□
Immunologic Problems	□	□	□
Depression, Anxiety	□	□	□
Other Psychiatric	□	□	□
Thyroid/ Other Glands	□	□	□
Anemia/ Blood Disorder	□	□	□
Allergies/Hay Fever/Sinu	□	□	
Chronic Cough/ Hep	□	□	
Dry Throat/ Mouth	□	□	
GI (Crohn's, IBS, diarrhea	□	□	
Other _____	□	□	

□ Antihistamines_____ □ Diabetes Pills_____ □ Vitamins_____

□ Analgesics (pain) _____ □ Oral Contraceptives _____ □ Herbal Supplements_____

□ Blood Pressure Pills_____ □ Skin Treatments_____ □ Others_____

Are you allergic to anything including any medications?_____

Dilation/ Visual Field Tests (explanation on clip board)

□ I want to be dilated today for an additional $25 fee (free with most insurance). **□ I want to reschedule dilation for another**

□ I want to have the visual field test done for an additional $20 fee. **□ I decline both tests.**

All fees paid for professional services are non-refundable and are due at the time services are rendered. I acknowledge that I have read this office's HIPPA Privacy Act and may receive a copy of it upon request.

If using insurance, I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Dr. Kimberly Tham DBA Eyedeal Vision all vision exam insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance claims. **Please sign:**

X _____ _____/_____/__22_ _____

Responsible Party Signature Relationship (self, spouse, guardian) Date E-mail Address (appointment reminders, no spam)

2nd Visit **X** _____ Date_____ 3rd Visit **X** _____ Date _____

EXTENDED OPHTHALMOSCOPY (Dilation)

Without the pupil dilation, the doctor is only able to see 20 to 30% of your retinas. To thoroughly examine the inside of the eye for diseases such as tumors, retinal holes, tears, and detachments, we need to put drops in your eyes to dilate the pupils. You will be more sensitive to bright light and have trouble reading for several hours, but most people will be able to drive home. Because this procedure allows the doctor to more thoroughly view the back of your eyes, we highly recommend routine dilation every year (especially for those with history of diabetes or high blood pressure, or those over 50). Healthy adults and minors should have this procedure done every two years. The fee for this test is $25.00

VISUAL FIELD ANALYSIS

Virtually all of the major causes of blindness in the United States can be detected by changes in the visual field. A highly sophisticated, computerized instrument now enables us to check for changes in central and peripheral vision. Visual field testing assists in early detection of glaucoma, retinal problems, and some neurological diseases (such as tumors and optic nerve disease). Visual field testing also enables us to better diagnose causes of headaches without placing drops in your eyes. Although most visual field defects are not noticed by an individual until very late stages, many times the visual field test can reveal early changes. Early detection and treatment can significantly improve the prognosis of many conditions. The fee for the screening analysis is $20.00.