

 Mr. Mrs. Miss Ms. Dr. SS#­­­­­­­­­­­­­\_\_\_\_/\_\_\_\_/\_\_\_\_\_ Today's date ­­­­­­­­­­­­­\_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_

Last Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI\_\_\_\_\_ Gender\_\_\_\_ DOB­­­­­­­­­­­­­\_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Ph. (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Ph. (\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_ E-mail\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last eye exam \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Were you dilated?\_\_\_\_\_\_\_\_\_\_ Referred by\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency contact name (s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone number(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Personal Eye Information**

Reason(s) for visit: Eye Exam First time contact lens fitting Update for current contact lenses Medical problem

Do you have any of the following? (circle all that apply or \_\_\_\_ check here if none apply)

Blurred Vision Glaucoma Cataracts Dry Eyes Macular Degeneration Retinal Detachment Flashes/Floaters

Do you have any other eye conditions or problems? yes/no Describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any eye injuries or surgeries? yes/no Describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you wear glasses? yes/no Contact Lenses? yes/no What type?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use a computer? yes/no How many hours per day? \_\_\_\_\_\_ Additional Information\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**General Medical Information**

Name of family doctor\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pregnant? yes/no

**Do you have problems with any of these systems? (Please choose yes or no)**

**C**ardiovascular (Heart) Yes / No Urinary / Genital Yes / No Endocrine (glands) Yes / No

High Blood Pressure Yes / No Muscles / Bones Yes / No Blood / Lymph Yes / No

Ears / Nose / Throat Yes / No Integumentary (Skin) Yes / No Allergic / Immunologic Yes / No

Respiratory (Lungs) Yes / No Nervous System Yes / No Headaches Yes / No

Gastrointestinal Yes / No Psychiatric Yes / No Eyes Yes / No

Please explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diabetes Yes / No Type \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of diagnosis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies to medication? Yes / No Which? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reactions?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other health problems\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Currents medication(s) (□ check if none) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History**

High Blood Pressure Yes / No Relation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Macular Degeneration Yes / No Relation \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diabetes Yes / No Relation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Retinal Detachment Yes / No Relation \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Glaucoma Yes / No Relation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cataracts Yes / No Relation \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cancer Yes/No Relation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other Yes/ No Relation\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dilation Information**

 It is our goal to provide a complete and thorough comprehensive eye examination. To effectively accomplish our

goal, we feel it is important to dilate the pupils of your eyes. This will require placing drops in your eyes. As with many

medications, there are some side effects of the drops used to dilate the pupil. These include sensitivity to light and

blurred reading vision. In most cases, the distance vision will not be affected. The side effects usually last several

hours but can, in some instances, last up to 24 hours. While we believe that dilation is an important part of the eye

examination process, we understand that you may wish to defer or decline this procedure. Please indicate your preference below:

 I wish to be dilated today.

 I do not wish to be dilated at this time but will return for this procedure at a later date (there is no additional charge

when you return for routine dilation within 90 days from your examination date).

 I do not wish to be dilated and agree to hold Valerie Potter, O.D./ Victoria Melcher, O.D., harmless as a result of

my actions.

**HIPPA Compliance Acknowledgement of Receipt**

I acknowledge that I received a copy of Valerie Potter, O.D./ Victoria Melcher. O.D., Notice of Privacy Practices.

Allow access to all patient records and information to: (none or full name/relationship):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient, Parent or Guardian Signature:\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_

**Financial Information**

Payment for services is required at the time of service. To our patients with Medical and/or Vision benefits: We will be

happy to file your insurance claim forms or take assignment on your medical/vision benefits. Plan(s) of which you

state you are a member, we will do all we can to help you receive maximum benefits. However, in the event that the

plan sponsor determines that you are not eligible for coverage at the time of service, or makes a determination that

you are eligible for a reduced level of coverage, by signing this statement you hereby agree to be financially

responsible for any and all charges incurred by you and not paid by the plan sponsor.

Patient, Parent or Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_

**If you are using insurance, please complete the following section:**

Name of insurance \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary insured’s name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Primary’s DOB \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_