Burgaw Eye Center

Today's Date:		Soc. Sec. #:
Last Name:	First:	Middle:
Birth Date: / /	Age:	Male_____ Female_____
Address:		
Ethnicity: African American Asian Caucasian Indian Middle Eastern Native American Hispanic/Latino		
Race: African American Native American Arab Asian Caucasian Hawaiian Hispanic/Latino Indian Multiracial		
Primary Phone:	Alternative Phone:	
Email Address:		
Employed _____ Homemaker _____ Student _____ Retired _____ Disabled _____ Veteran_____		
Employer:	Position:	
Emergency contact:	Phone:	
If under 18, name of person responsible for this account:		
Relationship to Patient:	Soc. Sec. #:	
Birth Date: / /	Phone #:	
Medical/Vision Insurance Primary & Seconday:		

Previous Eye Doctor:	Date of Last Eye Exam:
Have you had (please circle)? Eye disease Eye Injury Eye Surgery Eye Infection Flashes Floaters	
Family members with eye disease/surgery?	
Primary Care Physician:	Date of Last Visit:
Height:	Weight (exact if possible):
List Allergies:	
Medical Conditions and Medications:	
Family Medical Conditions:	
Do you use tobacco? Yes / No # Packs/Day _____ # of Years Used _____ If you quit, when _____	
Do you drink alcohol? Yes / No Occasionally _____ Daily _____ If yes, type _____	

Annual Comprehensive Eye Exam (skip if here for medical reason)

Are you considering new glasses today?	Yes_____ No_____
Do you have a spare pair of glasses?	Yes_____ No_____
Do you have prescription sunglasses?	Yes_____ No_____
Are you considering contact lenses today?	Yes_____ No_____
If yes, when would you wear contacts? Full Time Weekend/Social Golfing Fishing Sports Other	

Advance Beneficiary Notice: Signature on File, Assignment of Benefits, Financial Agreement, HIPAA

I acknowledge with my signature that I have read and understand the Advance Beneficiary Notice.

_____ _____

Patient Signature or Parent/Legal Guardian Signature Date

Optomap Retinal Exam

Please check one of the following and sign below after reading "Eye Health Evaluation":

___ Yes, I am requesting the **Optomap Retinal Exam** because I want the highest level of eye care.
- No side effects; $35.00 (additional to eye exam)

___ No thank you. I understand the benefit of the **Optomap Retinal Exam**; however, I do not want this level of eye care and understand my eyes will most likely be dilated with eye drops.
- Side effects include light sensitivity and near vision blur for several hours; included with eye exam

_____ _____

Patient Signature or Parent/Legal Guardian Signature Date