

DOVE VALLEY VISION CENTER, PC

ESTABLISHED PATIENT WELCOME & REASON FOR VISIT (RFV) FORM

Welcome back to our office. We know you have many choices for your eye care. So, we sincerely appreciate your continued trust and your many kind referrals of family, friends, and colleagues. Please, read and complete both sides of this brief form, so that we can best serve your eye care and eyewear needs today. Thank you.

Your technician and/or doctor will review any changes to your health history with you in the examination room.

Have you had any significant changes to your general health since our last visit? If so, please describe.

What is your current occupation? _____

Your comprehensive annual eye examination today will typically take between 1 and 1 ½ hours. This will include vision tests to determine the refractive state of your eyes for eyeglasses and a thorough health check of your eyes for cataract, glaucoma, and retinal disease.

Have you had any eye care elsewhere since our last visit?
 No. Yes If "Yes", please describe. _____

Have you recently failed a vision screening?
 No. Yes If "Yes", please describe. _____

In addition to your comprehensive eye examination described above, are you interested in being fitted or refitted for contact lenses today?

- YES, I am interested in being fitted or refitted for contact lenses today.
- MAYBE, I would like to discuss my options for wearing contact lenses with the doctor.
- NO, I have no desire to be fit for contact lenses today.

Do you have any specific eyewear needs today?

- I need to replace my eyeglasses as they are lost, broken, scratched, or just out of date.
- I need to replace my sunglasses as they are lost, broken, scratched, or just out of date.
- I need a new supply of contact lenses.
- I only wish to replace my current eyewear if my vision has changed.

YOUR RETINAL EXAMINATION TODAY

The American Optometric Association recommends a thorough retinal examination for all patients at least every two years, and more often for certain at risk patients, such as those with diabetes, high nearsightedness, or a personal or family history of eye disease. Our doctors prefer to utilize the OPTOMAP RETINAL EXAMINATION to evaluate your internal eye health. You can learn more about the many advantages of this advanced technology at our website or by asking our staff. Unfortunately, insurance companies typically do not cover this technology, as it exceeds the current standards of care. The additional fee for this valuable imaging is only \$35.

- YES, I would like to have an OPTOMAP RETINAL EXAMINATION today, as recommended by my eye doctor.
- NO, I would prefer not to have the OPTOMAP RETINAL EXAMINATION today.

LASIK VISION CORRECTION

We do provide peri-operative care for refractive surgery, such as LASIK.

Would you like more information about your refractive surgery options during your visit today? Yes No

YOUR CURRENT VISUAL & OCULAR SYMPTOMS

Please bring all currently used eyewear (including eyeglasses, sunglasses, and contact lenses) to your appointment. What is your primary concern with your vision or your eyes today? Please describe.

Are you currently experiencing any visual symptoms, such as blur, headache, eye strain, or double vision?

No Yes If "Yes", please describe.

Are you currently experiencing any ocular (eye) symptoms, such as irritation, redness, or discharge?

No Yes If "Yes", please describe.

How many hours per day do you use a computer?

_____ hours per day

Do you have any computer related eye strain or blur?

No Yes If "Yes", please describe.

Do you participate in any sports or hobbies?

No Yes If "Yes", please describe.

Do you have any special vision problems or eyewear needs related to work/school or sports/hobbies?

No Yes If "Yes", please describe.

ACKNOWLEDGEMENTS AND AUTHORIZATIONS

INITIAL EACH:

_____ **Office Policy Form:** I acknowledge that I have been given the opportunity to review DVVC's current "Office Policies", which are available upon request or are posted at our website.

_____ **Notice of Privacy Practices (HIPPA):** I acknowledge that I have been given the opportunity to review DVVC's "Notice of Privacy Practices", which are available upon request or are posted at our website. In short, your demographic or health information will be kept confidential by our doctors and staff at all times in accordance with HIPPA and will not be sold to outside entities without your permission. Please, inform our staff if you have any special needs regarding our standard use of your protected health information.

_____ **Statement Of Financial Responsibility:** I authorize Dove Valley Vision Center, PC (DVVC) to submit my vision insurance claim on my behalf. I also authorize payment of my benefit directly to DVVC or its doctors rather than to myself. I authorize release of information to my insurance company to facilitate my claim. I understand that my vision or medical insurance company is a third party payer on my behalf and thus knowledge of my benefits is ultimately my responsibility. DVVC is NOT an agent of your insurance company. I understand that I am ultimately responsible for any charges incurred with DVVC should my insurer refuse part or my entire claim.

Patient Name (Please Print): _____

Guardian Name If Patient Under 18 (Please Print): _____

E-mail Address (Please Print): _____

Date: ____/____/____

Signature: _____

PATIENT HISTORY FORM

Patient Name (Please Print): _____

Guardian Name If Patient Under 18 (Please Print): _____

Date: ____/____/____ Signature: _____

How is your general health? _____

SYSTEMIC HEALTH HISTORY

Please, check any of the following conditions by which you or any member of your family has ever been affected:

SELF	FAMILY	
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Hypertension (High Blood Pressure)
<input type="checkbox"/>	<input type="checkbox"/>	Cancer
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Seasonal Allergies
<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	Migraine Headache
<input type="checkbox"/>	<input type="checkbox"/>	Other. Please describe. _____

SYSTEMIC MEDICATIONS

Please, list any systemic medications that you are currently taking (including hormones, vitamins, homeopathic medications, and over-the-counter medications). If you have an extensive list of medications, you may allow our staff to photocopy and scan it instead.

None

SYSTEMIC SURGERIES

Please, list any systemic/general surgeries which you have undergone.

None

ALLERGIC SENSITIVITIES TO MEDICATIONS

Please, list any medications to which you have had an allergic reaction and describe the reaction.

None

SOCIAL HISTORY

(As with any of your health information, answers to the following questions will be kept confidential by both doctors and staff.)

Do you smoke tobacco?

None Former Light Smoker < 1 pack/day Average Smoker 1-2 packs/day Heavy Smoker > 2 packs per day

Do you consume alcohol?

None Socially 1-2 drinks/day Above average consumption Alcohol dependence

Do you use narcotic substances?

None Recreational use Chemical dependence

Do you have any sexually transmitted diseases?

No Yes HIV Positive

Have you ever required a blood transfusion?

No Yes HIV Positive

OCULAR (EYE) HEALTH HISTORY

Please, check any of the following vision or eye health conditions by which you or any member of your family has ever been affected.

SELF	FAMILY	
<input type="checkbox"/>	<input type="checkbox"/>	Myopia (Nearsightedness)
<input type="checkbox"/>	<input type="checkbox"/>	Hyperopia (Farsightedness)
<input type="checkbox"/>	<input type="checkbox"/>	Astigmatism
<input type="checkbox"/>	<input type="checkbox"/>	Amblyopia (Lazy Eye)
<input type="checkbox"/>	<input type="checkbox"/>	Strabismus (Turned Eyes)
<input type="checkbox"/>	<input type="checkbox"/>	Color Blindness
<input type="checkbox"/>	<input type="checkbox"/>	Keratoconus
<input type="checkbox"/>	<input type="checkbox"/>	Cataract
<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma
<input type="checkbox"/>	<input type="checkbox"/>	Macular Degeneration
<input type="checkbox"/>	<input type="checkbox"/>	Vitreous Floaters
<input type="checkbox"/>	<input type="checkbox"/>	Retinal Detachment
<input type="checkbox"/>	<input type="checkbox"/>	Diabetic Retinopathy
<input type="checkbox"/>	<input type="checkbox"/>	Dry Eye Syndrome
<input type="checkbox"/>	<input type="checkbox"/>	Ocular Allergies
<input type="checkbox"/>	<input type="checkbox"/>	Eye Infection
<input type="checkbox"/>	<input type="checkbox"/>	Eye Injury
<input type="checkbox"/>	<input type="checkbox"/>	Blindness
<input type="checkbox"/>	<input type="checkbox"/>	Other. Please describe. _____

OCULAR (EYE) MEDICATIONS

Please, list any ocular (eye) medications that you are currently taking, including over-the-counter products.

None

OCULAR (EYE) OR HEAD/NECK SURGERIES

Please, list any ocular (eye) or head/neck surgeries which you have undergone.

None