

PATIENT UPDATE FORM

CHANGES IN MEDICATIONS (RX OR OTC)

Today's Date: _____
Last: _____ First: _____
Street: _____
City: _____ State: _____ Zip Code: _____
Home Phone #: _____
Work #: _____ Cell #: _____
Emergency Contact & Number: _____

(List name of medications including eye drops, vitamins & Birth Control Pills. Explain reason for taking medication listed.)

Allergies to Medications: YES NO

List medication(s) you are allergic to: _____

Patient's Date of Birth: _____ Age: _____ Sex: M F
Employer/School: _____
Occupation/Grade: _____
Spouse/Parent's Name: _____
Spouse/Parent's Work: _____
Email address (for our newsletter and eye health updates): _____

INSURANCE INFORMATION

Vision Insurance: _____

Subscriber Name: _____

Subscriber ID #: _____

Subscriber Date of Birth: _____

If VSP, Subscriber Last Four Digits of SS#: _____

If Davis Vision/Eyemed, Subscriber SS#: _____

Any problems with your present glasses/contact lenses? _____

Medical Insurance: _____

Subscriber Name: _____

Subscriber ID #: _____

Subscriber Date of Birth: _____

Are you experiencing any of the following?

- | | | |
|---|---|------------------------------------|
| <input type="checkbox"/> Blurry Vision | <input type="checkbox"/> Flashes of Light | <input type="checkbox"/> Redness |
| <input type="checkbox"/> Trouble Seeing | <input type="checkbox"/> Floaters/Black Spots | <input type="checkbox"/> Tearing |
| <input type="checkbox"/> Reading Problems | <input type="checkbox"/> Light Sensitivity | <input type="checkbox"/> Burning |
| <input type="checkbox"/> Crossed Eye/Eye Turn | <input type="checkbox"/> Eye Pain | <input type="checkbox"/> Itchiness |
| <input type="checkbox"/> Eye Strain | <input type="checkbox"/> Double Vision | <input type="checkbox"/> Dryness |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Grittiness | |

Secondary Medical Insurance: _____

Subscriber Name: _____

Subscriber ID #: _____

Subscriber Date of Birth: _____

PUPIL DILATION

As part of our comprehensive eye examination, we instill eye drops in order to fully assess the health of the inside of your eyes.

YES NO

We recommend a Visual Field Screening and/or Retinal Photographs be taken as part of your yearly eye exam.

It allows us to provide you with the most comprehensive care.

VISUAL FIELD SCREENING

A Visual Field Screening is a computerized test to detect any defects or "blind spots" in your vision. The fee for this test is \$40.

YES NO

RETINAL PHOTOGRAPHY

Retinal Photographs are Polaroid pictures of the retina or back of your eyes. The fee for this test is \$40.

YES NO

Please remember it is your responsibility to ensure all referral and certification procedures are followed. Some procedures may require a referral from your primary care physician, in which you must bring the referral form, and your current insurance card on the day services are rendered and materials are ordered. If you notify us after services are rendered, we will supply you with a coded receipt for you to submit for reimbursement directly from your insurance plan. If you have vision coverage with a plan our office does not participate with, we will supply you with a coded receipt.

Assignment & Release:

I hereby authorize the physician to release any medical information as needed.

I hereby authorize my insurance benefits to be paid directly to the physician and understand I am financially responsible for non-covered services. Insurance coverage is not a guarantee of payment. In event of an insurance denial, I understand that I will be responsible for payment.

Acknowledgement of Privacy and Contact Lens Policies:

I have read and understand this practices' Notice of Privacy and Contact Lens Policies on the attached sheet. It provided in detail the uses and disclosures of my protected health information and my individual rights. I understand I can obtain a copy of the Privacy Practices upon request. By signing, I understand the offices' policies and fees.

X _____ Date: _____