

EYELAND PRE-EXAM SCREENING FORM

Patient Name _____ Date _____

Age _____ Date of Birth _____ If Under 18, Parent/Guardian _____

Address, City, State, Zip _____

Phone _____ Email _____

Occupation _____ Date/Place of Last Exam _____

List Any Illnesses That You are Currently Being Treated For _____

List Any Medications You are Taking _____

List Any Allergies or Allergies to Medications _____

Are you covered by Medicare? Yes No Name of Medical Insurance _____

Name Of Primary Vision Insurance _____ Insurance Holder's Place of Employment _____

Subscriber Name _____ ID# _____ Group# _____

Name Of Secondary Vision Insurance or Co-Insurance (If Applicable) _____

Subscriber Name _____ ID # _____ Group# _____

Check Any Of The Following Conditions That Apply (Do You Now, Or Have You Ever Had)...

High Blood Pressure **Currently Pregnant/Nursing** Vision Training

Diabetes Eye Disease or Injury Other _____

Glaucoma Eye Surgery

Macular Degeneration Neurological Diseases

Lazy Eye (Amblyopia) Cancer

Allergies Double Vision

Headaches Seeing Spots

Head Trauma Floaters

Check If You Have A Family History of . .

Glaucoma

Other Eye Conditions

Diabetes

Macular Degeneration

Reviewed X _____ DOCTOR ONLY

1. Is This Your First Visit To Our Office? Yes No

2. What is the reason for your examination today? _____

3. Do You Currently Wear Glasses? Yes No If Yes, Would you like your lenses to be (please check those that apply)

Thinner Lighter More Impact Resistant Glare Free Sensitive to Light Conditions (Transitions)

If Yes, Do you wear glasses for: Distance Reading Constant Wear

4. Do you currently wear bifocals: Yes No

If Yes, Would you like to see clearly at all distances while eliminating the visible bifocal line? Yes No

5. Do you experience glare from car headlights and street lights when driving at night? Yes No

6. Do you presently work with a computer? Yes No If Yes, how many hours daily? _____

Do you experience any of the following while using the computer? Eye Strain Backaches Neck Strain

7. Do you presently wear sunglasses? Yes No 8. Please list any hobbies you enjoy: _____

9. Do you currently wear contact lenses? Yes No If No, Would you be interested in contact lenses? Yes No

If Yes, What is the Brand Name of your contact lens? _____ Are They: Hard Lens Gas Perm

IMPORTANT PLEASE READ & SIGN

1.) In the event my insurance carrier does not pay Eyeland for the services and products I received, I understand that I will be responsible for all balances, collection fees and finance charges of 1.5% on my account.

2.) Did your Doctor Dilate your eyes last visit? Yes No

3.) Do you want your eyes dilated today? Yes No
(SEE DILATED EYE EXAMINATION INFORMATION)

4.) I acknowledge that I have received Eyeland Optical's Notice of Privacy Practices for protected health information.

I HAVE READ AND UNDERSTAND STATEMENTS #1-4

Patient's Signature _____ Date _____

Guardian Signature _____ Date _____

Reviewed X _____ DO

DOCTOR ONLY

DILATED EYE EXAMINATION INFORMATION Dilation is a medical procedure, which allows the doctor to use eye drops to temporarily enlarge your pupils for a more extensive view of the retina (back of the eye). With dilation, the doctor has the opportunity to evaluate and diagnose eye health problems before symptoms occur. It is recommended that all new patients are dilated and again every 2 to 4 years thereafter, unless certain conditions require closer monitoring. Some patients may experience light sensitivity and blurred vision for 2-6 hours. If you do not have dark sunglasses for your travel home, we will provide you with a disposable pair. You may have difficulty driving after the procedure, if you feel more comfortable being driven, please make arrangements to do so. In rare instances, patients may experience pain or other side effects. If this should occur, please seek medical attention immediately. Please advise our optometrist if you are pregnant or nursing at this time. If you have any other health conditions that may affect your response to these tests or questions regarding dilation please consult our doctor for additional information.

Please give your completed form to one of our staff, so that we know you are ready. Thank You.