

Welcome To Our Office!

PATIENT INFORMATION

Last Name: _____ First Name _____ (Miss/Ms./Mrs./Mr./Dr./Rev.)
 If Minor Parent Name: _____ Address: _____ Apt. # _____ City: _____
 State: _____ Zip: _____ Occupation: _____ Sex: _____ Patients Date of Birth: _____
 Home #: _____ Work #: _____ Email Address: _____ Texas D.L.# _____
 Members Social Security # _____ Insurance Company: _____ Insurance Co. Phone #: _____
 How did you hear about us? _____

PRELIMINARY HISTORY

	Yes	No
Blur at distance without glasses	<input type="checkbox"/>	<input type="checkbox"/>
Blur at distance with own glasses	<input type="checkbox"/>	<input type="checkbox"/>
Blur at near without glasses	<input type="checkbox"/>	<input type="checkbox"/>
Blur at near with own glasses	<input type="checkbox"/>	<input type="checkbox"/>
Seeing Double	<input type="checkbox"/>	<input type="checkbox"/>
Seeing unexplained flashing lights	<input type="checkbox"/>	<input type="checkbox"/>
Eyes itch, burn, tear frequently	<input type="checkbox"/>	<input type="checkbox"/>

EYE HISTORY

Eye injury	<input type="checkbox"/>	<input type="checkbox"/>
Eye surgery	<input type="checkbox"/>	<input type="checkbox"/>
Eye disease	<input type="checkbox"/>	<input type="checkbox"/>
Cataract	<input type="checkbox"/>	<input type="checkbox"/>

GENERAL HEALTH

	Yes	No	In Family
Do you smoke	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disorders	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Major Operations	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other health problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frequent Headaches	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you drink	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal detachment	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lazy Eye	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tumors in/around eye	<input type="checkbox"/>	<input type="checkbox"/>	_____

Do you currently take medication that is not prescribed for you? Yes No If so, please list _____

KNOWN ALLERGIES TO MEDICATIONS _____ CURRENT MEDICATIONS _____

Are you interested in Laser Vision Correction? Yes No
 Are you interested in contact lenses? Yes No
 Have you ever worn contact lenses? Yes No If yes, what type? _____

CONTACT LENS POLICY (APPLICABLE ONLY IF YOU ARE INTERESTED IN CONTACT LENSES)
 Fees that are paid for examinations, contact lens fitting, and progress checks for contact lenses are non-refundable. If for some unforeseen reason you cannot wear the contacts successfully, we will issue you an in-house credit for your contact lens materials that you can apply towards the purchase of glasses or any other items, which we supply for you.



State-of-the-art digital imaging technology, now available at Vision Source - Deerbrook, allows our doctors to capture a digital image (called an Optomap[®]) of your retina, without the inconvenience of dilation.

Your doctors at The Vision Source are concerned about retinal problems such as macular degeneration, glaucoma, retinal holes, retinal detachments, and diabetic retinopathy (all of which can lead to partial loss of vision or blindness) and can be seen without dilation for most patients.

The Optomap provides:

- A digital computerized map of the retina.
- An in-depth view of the retinal layers (where disease can start).
- The ability to show you your images today during your exam.
- A permanent record for your medical file (year to year comparisons for tracking and diagnosing potential eye disease).

Because your insurance is designed to cover only a basic eye exam, it does not cover advanced screening tools such as the Optomap. The doctors strongly recommend that ALL patients have an Optomap annually. The additional fee is only \$35.

_____ **I elect to have a digital image (Optomap) of my retina.**
 (Dilation may still be necessary in a few circumstances)
 _____ **I prefer a dilated exam. (Dilation will cause your vision to be blurry and you will be light sensitive for up to 6 hours)**

Patient Signature _____ Date _____

If you **decline** both the Optomap and dilation, you are limiting our ability to accurately determine the health of your eyes and must sign below.

I decline a thorough eye exam _____ Date _____