Please fill this form, print it and bring it with you to your next appointment. Do not send it via email.

General Information (Questions marked * are required)

First Name * | Middle | Last Name * | DOB * (dd/mm/yyyy)

Address * | City * | State * | ZIP Code *

Contact Number * | Select * | Alternate Number | Select

E-mail | Marital Status | Sex | Race

Emergency Contact * | Emergency Phone * | Relation

Medical and Ocular History (Questions marked * are required)

What brings you to our office today? *

Do you wear eyeglasses? *

☐ Full Time ☐ Part Time ☐ Reading ☐ Never

Do you wear contact lenses? *

◯ Full Time ◉ Part Time ◯ Never

If so, what brand?

How often do you change your contact lenses?

Have you ever had an eye injury? *

◯ Yes ◯ No

If so, please explain:

Have you ever had eye surgery? *

◯ Yes ◯ No

If so, please explain:

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Do you have any medical problems with any of these body systems?

Gastrointestinal

- ◯ Yes
- ◯ No

Urinary

- ◯ Yes
- ◯ No

Blood/Lymph

- ◯ Yes
- ◯ No

Ear/Nose/Throat

- ◯ Yes
- ◯ No

Muscles/Bones

- ◯ Yes
- ◯ No

Allergies

- ◯ Yes
- ◯ No

Cardiovascular

- ◯ Yes
- ◯ No

Immunological

- ◯ Yes
- ◯ No

Respiratory

- ◯ Yes
- ◯ No

Endocrine/Glands

- ◯ Yes
- ◯ No

Mental/Neurologic

- ◯ Yes
- ◯ No

Skin/Integumentary

- ◯ Yes
- ◯ No

Have you been diagnosed with diabetes? *

◯ Yes ◯ No

If yes, Last Blood Sugar

Last A1C

Have you been diagnosed with high blood pressure? *

◯ Yes ◯ No

Are you treated for a thyroid condition? *

◯ Yes ◯ No

List any medications you are taking

List any medications you are allergic to

Family Doctor *

When was your last visit? *

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Family Medical & Ocular History (Questions marked * are required)

Has anyone in your family been diagnosed with any of the following conditions?

High Blood Pressure

◯ Yes ◯ No

If yes, whom?

Diabetes

◯ Yes ◯ No

If yes, whom?

Glaucoma

◯ Yes ◯ No

If yes, whom?

Macular Degeneration

◯ Yes ◯ No

If yes, whom?

Retinal Detachment

◯ Yes ◯ No

If yes, whom?

Insurance Information (Questions marked * are required)

Do you have medical insurance? *

◯ Yes ◯ No

If yes, Insurance Company?

Policy Number

Group Number

Policy holder's name

DOB (dd/mm/yyyy)

SS#

Do you have vision insurance? *

◯ Yes ◯ No

(If your vision plan is the same as your medical plan, you may skip to the next section.)

Insurance Company?

Policy Number

Policy holder's name

DOB (dd/mm/yyyy)

SS#

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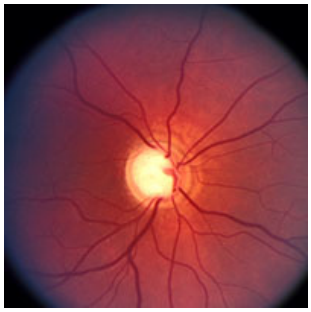
Authorization for Additional Testing (Questions marked * are required)

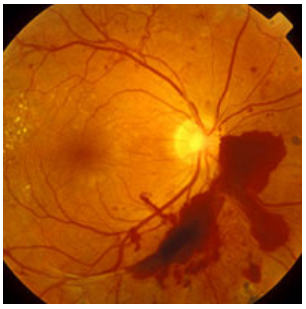
As part of a comprehensive Eye Examination, our office utilizes advanced technologies to create a photographic record of your retina. We consider this testing a part of our routine examination. In most cases, your insurance will not cover the cost associated. If not covered by the insurance, your financial billing statement will reflect that charge of $29.

How do this tests benefit you?

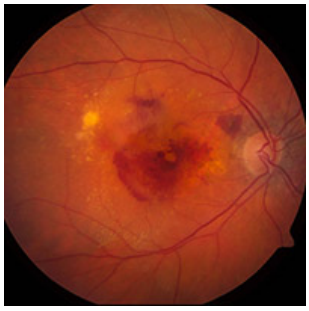
- **They provide your doctor the best possible information to diagnose, manage and treat eye diseases,**
- **They are a permanent, detailed record of your eye health and general health,**
- **They can be transferred to other doctors almost instantly.**



Damage from Glaucoma



Damage from Diabetes



Damage from Macular Degeneration

I have read and understand the importance of this testing.

I [ ] **to have this test performed.**

Privacy of your Medical Information and Medical Billing

By signing below, I acknowledge that I have been given the opportunity to review electronically (or in print) the Privacy Policy and the Insurance and Billing Practices in effect for Tippett Eye Care. Further, I have been informed that I may request a copy of these policies at any time.

I understand that, under the provisions of the privacy policy, my health care information may not be shared with anyone except as outlined by the policy. However, I wish to grant the following individuals unrestricted access to my information.

1.
2.
3.

Signature or signature of parent/guardian

Date (dd/mm/yyyy)

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