WELCOME TO LUX EYE CARE!

The information listed below will remain confidential and is critical to the evaluation of your vision and health

Patient Information

TODAY'S DATE: _____

NAME: _____ DATE OF BIRTH: _____ AGE: _____ SEX: M F

ADDRESS: _____ SS#: _____
(Street) (City) (State) (Zip)

EMAIL: _____ HOME PHONE: _____ Work: _____ Cell:

NAME/ADDRESS OF **PRIMARY CARE PHYSICIAN**: _____ DATE OF LAST EXAM: _____

NAME/ADDRESS OF LAST **EYE EXAM**: _____ DATE OF LAST EXAM: _____

EMPLOYER/SCHOOL: _____ OCCUPATION: _____

NAME OF SPOUSE/PARENT (Please Circle): _____ Work: _____ Cell:

INSURANCE HOLDER (Please circle): SELF / SPOUSE

VISION INSURANCE: _____ MEDICAL INSURANCE: _____ FLEX SPENDING YES NO

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE _____

WHAT ARE THE MAIN REASONS FOR TODAY'S APPOINTMENT? (PLEASE CHECK ONE OR MORE)

( ) Contact lens discomfort	( ) Eye Pain or Soreness	( ) Frequent eyestrain	( ) Red eyes
( ) Distance blurred vision	( ) Eye Watering or Tearing	( ) Frequent headaches	( ) Seeing flashes of light
( ) Double vision	( ) Eyelids matted shut	( ) Mucous Discharge eyes	( ) Sudden loss of vision
( ) Dry/Burning eyes	( ) Floating spots in vision	( ) Near blurred vision	( ) Unusual Light Sensitivity
( ) Eye Itching or Allergies	( ) Foreign matter in eyes	( ) One eye turns in or out	( ) Other _____

ALLERGIES TO MEDICATIONS? ( ) NONE ( ) YES: Please List: _____

CURRENT MEDICATIONS: ( ) NONE ( ) YES: _____
Including prescription, over the counter, natural herbs, vitamins, and birth control.

DO YOU USE: *TOBACCO PRODUCTS? ( ) YES ( ) NO ( ) QUIT *DRINK ALCOHOL? ( ) YES ( ) NO *USE DRUGS? ( ) YES ( ) NO

IF YES, TYPE/AMOUNT/HOW LONG:

CHECK ANY **MEDICAL CONDITIONS** THAT APPLY TO **YOU** **( ) NONE :**

( ) Diabetes	( ) Vascular Disease/Stroke	( ) Cancer	( ) Skin Eczema/Rash
( ) High Blood Pressure	( ) Seizures	( ) Thyroid Disease	( ) Kidney/Bladder
( ) High Cholesterol	( ) Lung Disease/Asthma	( ) Arthritis	( ) Psychiatric
( ) Heart Disease	( ) Headaches/Migraines	( ) Weight Loss/Gain	( ) Autoimmune

CHECK ANY **EYE CONDITIONS** THAT APPLY TO **YOU** **( ) NONE :**

( ) Glaucoma	( ) Macular Degeneration	( ) Turned Eyes	( ) Eye Surgery
( ) Cataracts	( ) Dry Eyes/Allergies	( ) Eye Injury	( ) Other _____

CHECK CONDITIONS THAT ARE PRESENT IN OTHER FAMILY MEMBERS AND INDICATE WHO ( ) NONE :

( ) Glaucoma _____	( ) Retinal Detachment _____	( ) Blindness_____	( ) Cancer _____
( ) Cataracts_____	( ) Turned/Crossed Eyes_____	( ) Diabetes_____	( ) Heart Disease_____
( ) Macular Degeneration_____	( ) Lazy Eye_____	( ) High Blood Pressure_____	( ) Thyroid Disease_____

CONTACT LENS HISTORY

( ) I do not wear contact lenses
( ) I am interested in wearing contact lenses or would like to know more about them
( ) I currently wear contact lenses; If so, what type: _____ Solution: _____ Sleep in your lenses? YES NO
( ) I am not satisfied with the vision and comfort of my contact lenses

How often do you replace your contacts? DAILY 2-WEEKS MONTHLY QUARTERLY YEARLY

DIGITAL RETINAL PHOTOGRAPHY INFORMED CONSENT

Our office highly recommends a new state-of-the-art procedure for ALL PATIENTS, called **Digital Retinal Photography**. This procedure CAN BE DONE INSTEAD OF DILATION allowing our doctors to capture an image of the inside of your eyes. This test aids in the early detection and continued care of eye problems such as DIABETES, HIGH BLOOD PRESSURE, GLAUCOMA, MACULAR DEGENERATION, PRE-CANCEROUS LESIONS, RETINAL DETACHMENTS and any other condition that may result in vision loss.

****THERE IS A NOMINAL FEE OF $35 FOR THIS TEST.**

Please check (√) one:

_____ I DO want to take this test at this time **_____ I DO NOT** want to take this test at this time

VISUAL FIELD SCREENING INFORMED CONSENT

Our office is pleased to offer a new **Computerized Visual Field Screening** for all of our patients. This test is able to detect very early changes to the eye that can't be seen with photography or dilation alone. IT IS ESPECIALLY IMPORTANT TO HAVE THIS TEST PERFORMED, IF YOU HAVE BEEN HAVING **HEADACHES, LOSS OF VISION**, OR HAVE A FAMILY HISTORY OF ANY SERIOUS EYE CONDITIONS.

****THERE IS A NOMINAL FEE OF $25 FOR THIS TEST.**

Please check (√) one:

_____ I DO want to take this test at this time **_____ I DO NOT** want to take this test at this time

DILATED FUNDUS EXAMINATION INFORMED CONSENT

DILATION OF THE PUPIL is recommended for all of our patients, especially new patients, children, or patients with existing eye conditions as part of your yearly eye health evaluation. This procedure uses eye drops to enlarge your pupils allowing the Doctor to thoroughly check your eyes and to help ensure accuracy of your new prescription. YOUR VISION WILL BECOME BLURRY, AND YOUR EYES MORE SENSITIVE TO LIGHT FOR 3-5 HOURS after the drops have been used. This procedure is covered by most insurance providers.

Please check (√) one:

_____ **I DO** want to have my eyes dilated at this time and understand my vision may be impaired.

_____ **I DO NOT** want to have my eyes dilated at this time because _____. I understand that I am releasing LUX Eye Care from any liability by not having this exam.

****If you elect to have BOTH the digital photography and the visual field screening, the fee is $50.**

I, _____ _____ _____

Patient's name (please print) **Patient's/ Parent's Signature** **Date**

hereby acknowledge receipt of LUX Eye Care's Notice of Privacy Policies / Consent Form and Contact Lens Policies. I have read these documents and understand them. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations. I understand that I am responsible for all charges not covered by my insurance. PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED. PROFESSIONAL FEES ARE NON- REFUNDABLE.