MODERN EYES OPTICAL

Patient #_____

Today's Date: ____/_____/_____

Patient Information

First Name_____ Last Name_____ Preferred Name_____ Birth date ____/____/_____ ☐M ☐F

Address_____ City_____ State_____ ZIP_____

Mobile/Home Phone (_____)_____ Email_____

Employer_____ Occupation/Grade_____

Parent/Guardian (if under 18)_____ Relationship: ☐Father ☐Mother ☐Guardian Phone(_____)_____

Emergency Contact_____ Relationship_____ Phone(_____)_____

Primary Care Provider_____ Preferred Pharmacy: _____

Medicare / Medicaid? ☐Yes ☐No

Medical & Ocular History

Reason for today's visit:_____

Do you wear: **Glasses** ☐ Yes ☐ No If yes, age of current glasses_____

Contact lenses ☐ Yes ☐ No If yes, what brand_____ Prescription: Right Eye_____ Left Eye_____

How many hours on an average day do you spend on digital devices?_____

Have you ever had any of the following conditions? (*Please check all that apply, must select at least one, list any others*)

☐ Glaucoma	☐ Retinal Tear/Detachment	☐ Eye Surgery (incl Laser)	☐ Thyroid Problems	☐ Currently Pregnant
☐ Cataracts	☐ Strabismus (eye turn)	☐ Double Vision	☐ Heart Disease	☐ Other:_____
☐ Macular Degeneration	☐ Amblyopia (Lazy Eye)	☐ Frequent Headaches	☐ Cancer	☐ Other:_____
☐ Retinal Disease	☐ Eye Injury/Trauma	☐ Diabetes	☐ Rheumatoid Arthritis	
☐ Uveitis/Inflammation	☐ Blindness	☐ High Blood Pressure	☐ Asthma	☐ **NONE OF THE ABOVE**

Eye Surgeries: _____

Some medications have ocular side effects, please list all medications/Supplements/Eye Drops you take:

_____

_____

Allergies: ☐ NONE ☐ Latex ☐ Iodine ☐ Medications (list including reaction)_____

Personal History: Smoker: ☐ Current ☐ Previous ☐ Never **Drugs**: ☐ Sometimes ☐ Previous ☐ Never **Alcohol**: ☐ Frequent ☐ Occasional ☐ Never

Does any immediate family member have a history of any of the following conditions?

☐ Glaucoma		☐ Diabetes		☐ High Blood Pressure	
☐ Cataract		☐ Strabismus (Crossed Eyes)		☐ Cancer	
☐ Macular Degeneration		☐ Amblyopia (Lazy Eye)		☐ **NONE OF THE ABOVE**	
☐ Retinal Tear/Detachment		☐ Blindness			

Signature of Patient (Parent/Guardian if minor)_____ Date _____/_____/_____

Office Use: Date_____ ☐ Changes ☐ No Changes Initial_____

Date_____ ☐ Changes ☐ No Changes Initial_____

Retinal Evaluation Policy and Consent

The most important part of your eye exam is the evaluation of your eye health which relates to your body's overall health. This can be performed as either a dilated retinal exam OR the Optos wide angle retinal imaging. Dilation allows the Dr. to see 100% of the back of your eye versus 80% w/ the Optos. Dilation is highly recommended for all first time patients.

OPTOS Retinal Imaging/ Dilated Retinal Exam

The Optos is fast, easy and comfortable. In most cases, you will not need to get dilated if you elect the Optos imaging. The Optos takes an extreme wide angle image of the back of your eye. The images become part of your permanent medical record for future reference. **The fee for the Optos imaging is $29.99**. If you choose dilation drops instead, it is included in your exam at no additional charge. Some patients may experience blurred vision and light sensitivity, usually lasting 3-6 hours. In most cases distance vision will be minimally affected, however if you feel more comfortable being driven please make arrangements. You should not operate heavy equipment or drive an automobile unless you are comfortable with your vision.

PLEASE CHECK ONE OF THE FOLLOWING:

____ I elect to have the Optos wide angle imaging for $29.99

____ I decline the Optos imaging but **allow** ModernEYES Optical to dilate my pupils today if professionally indicated.

____ I decline the Optos imaging and am **unable** to have my pupils dilated today but **will schedule a follow-up dilation** within 30 days.

____ I decline the Optos imaging AND **refuse** dilation of my pupils. I understand that the Optos imaging/ dilation of my pupils is an important diagnostic tool that allows for a complete and thorough eye examination. I understand that by refusing dilation or imaging, I risk having a sight threatening disorder or other disease left undiagnosed.

3D OCT Macula/Optic Nerve Wellness Screening

The OCT Wellness Screening simultaneously provides a digital photo and a 3D cross-section scan through the layers of your central retina using light waves. The wellness screening is fast, easy, and comfortable. The doctor will review the results with you at today's visit. The wellness screening does not replace dilation or the Optos imaging, instead they work beautifully together for a more complete evaluation. The **fee** for this state of the art imaging procedure is **$29.99. If you get both the Optos wide angle imaging AND the OCT screening, you receive a $10 discount.**

PLEASE CHECK ONE OF THE FOLLOWING:

____ I **elect** to have a 3D OCT Wellness Screening of my retina.

____ I **decline** the Wellness Screening.

_____ _____

Signature of Patient (or Parent/Guardian if patient under 18) **Date**