PATIENT HISTORY NAME: _____

Address: _____ D.O.B _____
City _____ State ____ Zip _____
Social # _____ Email _____
Home Phone: _____ Cell phone: _____
Work phone: _____ Employer: _____

VISION INSURANCE

Insurance Company: _____
Member ID#: _____
Primary insured's Name: _____
Primary insured's address: _____
Birthdate: _____
S.S. #: _____
Employer: _____
Relation to Patient: _____

VISUAL AND MEDICAL HISTORY

Reason for today's exam: O Contact Lenses O Glasses O Yearly Exam
Date of last eye exam: _____ By Whom: _____
Contact lens type: _____ Age of lenses: _____ Age of glasses: ____
Disinfection type: _____ Family Doctor: _____

For office use only

NCT @ _____ am / pm

Please check any conditions that applies to yourself or any immediate family members:

	Self	family		self	family
Diabetes	___	___	Retinal detachment	___	___
High blood pressure	___	___	Eye surgery	___	___
Cataracts	___	___	Lazy eye	___	___
Heart problems	___	___	Double vision	___	___
Respiratory problems	___	___	Blindness	___	___
Thyroid problems	___	___	Head/Eye injury	___	___
Glaucoma	___	___	Headaches	___	___
Loss of Vision	___	___	Macular degeneration	___	___

Other Concerns: _____

Medications: _____
Allergies: _____

RETINAL HEALTH ANALYSIS

Dr. Schwindt strongly recommends a yearly dilated fundus exam (dilations). Dilation opens the pupil aperture to allow for easier and earlier detection of ocular diseases such as glaucoma, macular degeneration, hypertension, diabetes, and ocular cancer. The fee for this test is **$19.00 in addition to the regular exam fee**. This test may not be covered by insurance. After dilation, it is recommended that you have a driver as your eyes will be sensitive to light.

☐ Yes; I understand the importance of a dilated fundus exam and I agree to have my eyes dilated today.

Oculus Visual Field analyzer. This instrument can map your visual pathway completely through the small cells of the brain. The test takes approximately one minute per eye and can be useful in detecting many disease processes including glaucoma, cataracts, diabetes, multiple sclerosis and brain tumors. The fee for this test is **$8.00 in addition to the regular exam fee**. This test is not covered by insurance. Please check a response below.

☐ Yes; I understand the importance of a visual field test and I agree to have the test performed today.

☐ No; I understand the importance of a visual field test but I do not wish to have the test performed at this time.

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I have been made aware of this office's Notice of Privacy Practices.
I also know that I may have a copy if I wish.

Patient's Signature: _____ **Date:** _____

Referred By: _____