



## PATIENT INFORMATION FORM

### DEMOGRAPHICS

FIRST NAME		LAST NAME	
DOB / /	SEX F M	EMAIL	
ADDRESS			
CITY		STATE	ZIP
CELL#	HOME#	WORK#	
EMERGENCY CONTACT#	NAME	RELATIONSHIP	
EMPLOYER	OCCUPATION	REFERRED BY	
HOW CAN WE CONTACT YOU? CHECK ALL THAT APPLY			
	PHONE	EMAIL	MAIL OTHER

### INSURANCE

VISION PLAN NAME		ID#
PRIMARY INSURED NAME		PRIMARY INSURED DOB / /
INSURED SS# (last 4 #)	RELATIONSHIP	
INSURED ADDRESS (if different)		
INSURED EMPLOYER		

### VISION

REASON FOR TODAY'S EXAM		LAST EXAM / /	
DO YOU WEAR GLASSES? Y N	CONTACTS? Y N	WHAT BRAND	
AGE OF PRESENT GLASSES	AGE OF PRESENT SUNGLASSES		RX / NON-RX
GETTING NEW GLASSES TODAY? Y N	NEW CONTACTS TODAY? Y N		

### HEALTH HISTORY

<i>DO YOU OR YOUR BLOOD RELATIVES (PARENTS, GRANDPARENTS, SIBLINGS) HAVE ANY OF THESE CONDITIONS? CHECK ALL THAT APPLY</i>					
	SELF	RELATIVE		SELF	RELATIVE
DIABETES			GLAUCOMA		
HIGH BLOOD PRESSURE			CATARACTS		
HEART DISEASE			MACULAR DEGENERATION		
HIGH CHOLESTEROL			RETINAL DISEASE		
THYROID DYSFUNCTION			LAZY/CROSSED EYES		
ARTHRITIS			EYE SURGERY		
ASTHMA			EYE INJURY		
CANCER			BLINDNESS		
OTHER			OTHER		

DO YOU HAVE	YES	NO
FREQUENT HEADACHES?		
VISION PROBLEMS?		
DRY/ITCHY/BURNING/PAINFUL EYES?		
OTHER?		

ARE YOU PREGNANT? Y N	HAVE YOU EVER BEEN DILATED? Y N	YEAR?
DO YOU HAVE ALLERGIES TO MEDICATIONS, SOLUTIONS, OR OTHER? PLEASE LIST Y N		
ARE YOU TAKING ANY MEDICATIONS (PRESCRIPTION OR OVER THE COUNTER)? PLEASE LIST Y N		
DO YOU USE ANY EYE DROPS (PRESCRIPTION OR OVER THE COUNTER)? PLEASE LIST Y N		

PATIENT / LEGAL GUARDIAN SIGNATURE \_\_\_\_\_ DATE / /

PRINT NAME \_\_\_\_\_



**Wellness Exam with Digital Fundus Photography**

At Clarity Eyecare, we are dedicated to providing our patients the best eye health care possible and the Wellness Exam helps us to do that. Vision threatening diseases such as glaucoma, macular degeneration and diabetic retinopathy often have no outward signs or symptoms in the early stages, so Dr. Tafadzwa Makoni-Savanhu has begun using state-of-the-art technology to assess the health of your eyes. The Wellness Exam with Fundus Photography **it's a quick, painless, non-invasive scan** that allows our doctor to see both the surface and beneath the surface of your retina. This unique technology can help our doctor detect vision threatening and systemic diseases in their very early stages, when they are most treatable. As part of your pre-exam testing, our technician will perform the Wellness Exam with Fundus Photography which your doctor will review with you during your examination today.

**This screening is NOT covered by your insurance and has an additional fee of \$39.**

\_\_\_\_\_ **Yes**, I would like to have the Wellness Exam today. \_\_\_\_\_ **(initial here)**

\_\_\_\_\_ **No**, I **DECLINE** to have it done at this time. \_\_\_\_\_ **(initial here)**

**Pupil dilation**

In addition to your general examination, it is highly recommended that your pupils are dilated to further evaluate the health of the entire eye. Dilation is the use of eyedrops to temporarily enlarge the pupil, so as to provide the doctor with a full view of the inside of the eye. There are some ocular conditions with the potential for vision loss that may not be detected and go undiagnosed without a dilated eye exam. It is especially important for patients who have a history of systemic and/or ocular conditions, such as **diabetes, HIV, high blood pressure, glaucoma, macular degeneration, high nearsighted prescription and floaters.**

The dilation process takes an additional 30 minutes to be added onto your examination. Some side effects, you may experience, include blurred vision (especially at near) and increase light sensitivity ranging between 4 to 6 hours. Although driving is not usually impaired, extra caution and attention may be required on your part. Some people feel more comfortable having someone drive them home.

\_\_\_\_\_ **Yes**, I understand the above and give consent to have my eyes dilated today. \_\_\_\_\_ **(initial here)**

\_\_\_\_\_ **No**, I **DECLINE** to have dilation at this time. \_\_\_\_\_ **(initial here)**

**Advance Beneficiary Notice (ABN)**

The procedures performed in this office are medical in nature. Professional fees will be submitted to your vision and/or medical insurance. I understand that I am financially responsible for all insurance co-pays.

I authorize payment of insurance benefits to Clarity Eyecare Services – Dr. Tafadzwa Makoni-Savanhu. I agree to be financially responsible for any balance not paid by my insurance plan. I authorize the office or insurance company to release any information required to process claims.

I understand, I am financially responsible for all professional fees if I do not possess insurance at the time of service. **I understand that professional fees are non-refundable.**

Patient / Legal Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_ Relationship \_\_\_\_\_

**HIPAA Privacy Practices Acknowledgment**

I have received the Notice of Privacy Practices and I have been provided the opportunity to review.

Patient / Legal Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_