PATIENT INFORMATION FORM

Patient Name_____ **DOB**_____

VISION

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

DO YOU HAVE	**YES**	**NO**	**EXPLAIN**
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_____

PLEASE LET US KNOW IF ANY OF YOUR INFORMATION CHANGED SINCE YOUR LAST VISIT

(address, phone#, insurance…)

OVER

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_____