

Vista EyeCare

Welcome to Vista EyeCare. Thank you for choosing us for your eyecare needs. We are delighted to have you as a patient and appreciate the confidence you placed in us. Please take a moment to complete the following information

PLEASE PRINT

NAME _____ M.I. _____ LAST NAME _____ DATE OF BIRTH _____ AGE _____

MALE ___ FEMALE ___ INSURANCE THAT PROVIDES YOUR MEDICAL _____ VISION _____ INSURED SS# _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

EMPLOYER/OCCUPATION _____ COMPUTER USER _____ HOW MANY HOURS PER DAY _____

APPROXIMATE DATE OF LAST EYE EXAM _____ REFERRED BY: _____

REASON FOR TODAY'S VISIT: (CHECK ALL THAT APPLY)

DIABETIC EXAM ___ GLAUCOMA EXAM ___ ALLERGIES ___ DRY EYE ___ RED EYE ___ FLOATERS ___ FREQUENT HEADACHES ___

BLURRY VISION ___ DISTANCE ___ NEAR ___ CONTACT LENSES ___ EYE INJURY ___ OTHER _____

CHECK ALL CONDITIONS THAT APPLY TO YOU

EYE HISTORY	Y/N	HOW LONG		Y/N	HOW LONG		Y/N	HOW LONG
CATARACT			DRYNESS			STRABISMUS(CROSS EYES)		
GLAUCOMA			TEARING /WATERING			BLURRED VISION DISTANCE		
MACULAR DEGENERATION			EYEPAIN/SORENESS			BLURRED VISION NEAR		
RETINAL DETACHMENT			FOREING BODY SENSATION			DISTORTED VISION(HALOS)		
COLOR BLINDNESS			EYELIDS/INFECTIONS (STYE)			DOUBLE VISION		
BELL'S PALSY			ITCHING			FLOATERS /SPOTS		
GLARE/LIGHT SENSITIVITY			MUCOUS DISCHARGE			FLUCTUATING VISION		
AMBYOPIA(LAZY EYE)			REDNESS			LOSS OF VISION		
BURNING			SANDY /GRITTY FEELING			LOSS OF SIDE VISION		
GENERAL HEALTH	Y/N	HOW LONG		Y/N	HOW LONG		Y/N	HOW LONG
CHOLESTEROL			GALL BLADDER			HIV/AIDS		
HIGH BLOOD PRESSURE			CHRONIC COUGH			ARTHRITIS		
HEART DISEASE			DRY MOUTH			ALZHEIMER'S DISEASE		
STROKE			MIGRAINES			CANCER		
DIABETES			HEADACHES			ANXIETY/DEPRESSION		
THYROID DISORDER			ANEMIA			PREGNANT		
KIDNEY DISEASE			SICKLE-CELL			NURSING		
HEPATITIS			LUPUS			OTHER		
LIST ALL MAJOR SURGERIES:								
LIST ALL MEDICATIONS TAKEN:								
LIST ALL ALLERGIES TO MEDICATIONS &/ OR ENVIRONMENT:								
FAMILY HISTORY:	Y/N	HOW LONG		Y/N	HOW LONG		Y/N	HOW LONG
BLINDNESS			RETINAL DETACHMENT			HEART DISEASE		
GLAUCOMA			CANCER			HIGH BLOOD PRESSURE		
MACULAR DEGENERATION			DIABETES			STROKE		
SOCIAL HISTORY:								
DO YOU USE NUTRITIONAL VITAMINS?			DO YOU SMOKE?			DO YOU DRINK ALCOHOL?		
CONTACT LENS HISTORY:								
BRAND NAME			DO YOU SLEEP IN YOUR CONTACTS?			DO YOU OWN A PAIR OF GLASSES?		

ARE YOU INTERESTED IN LASER VISION CORRECTION? _____

PATIENT SIGNATURE _____ DATE _____

TO FURTHER EVALUATE THE HEALTH OF YOUR EYES, OUR OFFICE STRONGLY RECOMMENDS:

DIGITAL RETINAL SCREENING:

A HIGH RESOLUTION RETINAL PHOTO IS A NEW METHOD OF EXAMINATION AND DOCUMENTATION OF RETINAL FINDINGS, WITHOUT THE USE OF DILATION EYE DROPS, IS MORE DETAILED AND ACCURATE THAN CONVENTIONAL HAND DRAWN DOCUMENTATION. DIGITAL RETINAL SCREENING PROVIDES PERMANENT DOCUMENTATION OF EYE DISEASE AND ESTABLISHES BASELINE IMAGES TO COMPARE AGAINST ANY FUTURE CHANGES.

VISUAL FIELD TESTING:

THE VISUAL FIELD ANALYZER IS A COMPUTERIZED INSTRUMENT THAT PROVIDES A MORE DETAILED EXAMINATION OF BOTH YOUR CENTRAL AND PERIPHERAL VISION. VISION FIELD SCREENING ASSISTS IN THE EARLY DETECTION OF GLAUCOMA, RETINAL PROBLEMS, AND SOME NEUROLOGICAL DISEASES SUCH AS BRAIN TUMOR & OPTIC NERVE CONDITIONS. IT MAY ALSO DIAGNOSE CAUSE OF HEADACHES.

DILATION:

DILATION OF THE EYES ALLOWS THE DOCTOR TO THOROUGHLY EXAMINE THE INSIDE OF THE EYES FOR PROBLEMS SUCH AS GLAUCOMA, CATARACTS, DIABETES, HIGH BLOOD PRESSURE, MACULAR DEGENERATION, AND RETINAL HOLES, TEARS, OR DETACHMENT. SIDE EFFECTS INCLUDE SENSITIVITY TO LIGHT AND SLIGHTLY BLURRED VISION (MOSTLY FOR NEAR) LASTING A FEW HOURS.

WE ARE COMMITTED TO EARLY DETECTION AND PREVENTION OF EYE DISEASES. WE STRONGLY RECOMMEND THESE PROCEDURES TO ALL OF OUR PATIENTS AS PART OF THEIR YEARLY COMPREHENSIVE EYE EXAM. IF YOU DECLINE THE DIGITAL RETINAL SCREENING, VISUAL FIELD AND/OR DILATION, YOU ARE LIMITING OUR ABILITY TO ACCURATELY DETERMINE AND MONITOR THE HEALTH OF YOUR EYES. EARLY DETECTION OF EYE DISEASE IS CRUCIAL. THERE IS AN ADDITIONAL FEE OF \$15.00 FOR EACH PROCEDURE: DIGITAL RETINAL SCREENING, VISUAL FIELD, AND DILATION

PLEASE CHECK THE APPROPRIATE LINES BELOW:

YES, I WANT THE DIGITAL RETINAL SCREENING.

NO, I DO NOT WANT THE DIGITAL RETINAL SCREENING.

YES, I WANT THE VISUAL FIELD.

NO, I DO NOT WANT THE VISUAL FIELD.

YES, I DO WANT DILATION.

NO, I DO NOT WANT DILATION.

****PROFESSIONAL FEES ARE NON-REFUNDABLE AND PAYMENT IS DUE AT THE TIME OF YOUR VISIT****

PATIENT CONSENT FORM

I UNDERSTAND THAT, UNDER THE HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996(HIPPA). I HAVE CERTAIN RIGHTS TO PRIVACY REGARDING MY PROTECTED HEALTH INFORMATION. I UNDERSTAND THAT THIS INFORMATION CAN AND WILL BE USED TO:

- CONDUCT, PLAN AND DIRECT MY TREATMENT AND FOLLOW-UP AMONG THE MULTIPLE HEALTHCARE PROVIDERS WHO MAY BE INVOLVED IN THAT TREATMENT DIRECTLY AND INDIRECTLY
- OBTAIN PAYMENT FROM THIRD- PARTY PAYERS.
- CONDUCT NORMAL HEALTHCARE OPERATIONS SUCH AS QUALITY ASSESSMENT AND PHYSICIAN CERTIFICATION.

I HAVE BEEN INFORMED BY YOU OF YOUR NOTICE OF PRIVACY PRACTICES CONTAINING A MORE COMPLETE DESCRIPTION OF THE USES AND DISCLOSURES OF MY HEALTH INFORMATION. I HAVE BEEN GIVEN A RIGHT TO REVIEW SUCH NOTICE OF PRIVACY PRACTICE PRIOR TO SIGNING THIS CONSENT. I UNDERSTAND THAT THIS ORGANIZATION HAS THE RIGHT TO CHANGE ITS NOTICE OF PRIVACY PRACTICES FROM TIME TO TIME AND THAT I MAY CONTACT THIS ORGANIZATION AT ANY TIME AT THE ADDRESS BELOW TO OBTAIN A CURRENT COPY OF THE NOTICE OF PRIVACY PRACTICES.

I UNDERSTAND THAT I MAY REQUEST IN WRITING THAT YOU RESTRICT HOW MY PRIVATE INFORMATION IS USED OR DISCLOSE TO CARRY OUT TREATMENT, PAYMENT ON HEALTHCARE OPERATIONS. I ALSO UNDERSTAND YOU ARE NOT REQUIRED TO AGREE TO MY REQUESTED RESTRICTIONS, BUT IF YOU DO AGREE THEN YOU ARE BOUND TO ABIDE BY SUCH RESTRICTIONS.

I UNDERSTAND THAT I MAY REVOKE THIS CONSENT IN WRITING AT ANY TIME, EXCEPT TO THE EXTENT THAT YOU TAKEN ACTION RELYING ON THIS CONSENT.

PATIENT NAME _____
SIGNATURE _____
RELATIONSHIP TO PATIENT _____
DATE _____

I HEREBY AUTHORIZED THE PHYSICIAN TO RELEASE ANY INFORMATION REQUIRED TO PROCESS THIS CLAIM. I ALSO AUTHORIZED MY INSURANCE BENEFITS BE PAID DIRECTLY TO THE PHYSICIAN AND I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR NON-COVERED SERVICES.

SIGNATURE _____ DATE _____