

WELCOME TO THE OFFICE OF DRS. CLINE AND ASKEW

FOR OFFICE USE ONLY:

ACCOUNT # _____

(PLEASE PRINT)

TODAY'S DATE _____
FULL NAME _____
Nickname or preferred to be called _____
ADDRESS _____
CITY _____ STATE _____ ZIP _____
HOME PHONE _____ CELL PHONE _____
EMAIL ADDRESS: _____
CHILD LIVES WITH: Mother - Father - Both - Grandparents - Other

DATE OF BIRTH ____ / ____ / ____ AGE ____ SEX: M F
SOCIAL SECURITY # _____
EMPLOYER (or SCHOOL) _____
OCCUPATION (or GRADE) _____
BUS. PHONE _____
FAMILY PHYSICIAN _____
Address _____
EMERGENCY CONTACT _____
Relationship to Patient _____
Address _____ Phone # _____

SPOUSE OR PARENT NAME _____
DATE OF BIRTH ____ / ____ / ____ AGE ____ SEX: M F
SOCIAL SECURITY # _____

EMPLOYER _____
OCCUPATION _____

Have we seen anybody in your immediate family? Y N
If yes, may we have their name and relation? _____
If no, who referred you? Doctor ____ Friend ____ or other ____ (please specify) _____
List sports or recreational activities _____
List any Hobbies _____

How did you learn about our office?
o Friend/Relative Who? _____
o Another health care practitioner. Who? _____
o SWB Yellow Pages o Newspaper Ad
o Insurance o Other

DO YOU ...
Have more than one pair of glasses? Y N
Want information on lighter, thinner lenses? Y N
Have prescription sunglasses? Y N
Have problems with glare or reflection, particularly
When driving at night? Y N
Work on a computer for long periods? Y N

Do you have any allergies to medicines? Y N If yes, explain: _____

List any medicines you take (including oral contraceptives, aspirin, over the counter medications and home remedies):

List all major injuries, surgeries and/or hospitalizations you have had: _____

List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye injury.

Are you pregnant and/or nursing? Y N
Do you wear glasses? Y N If yes, how old is your present pair of lenses? _____
Do you wear contact lenses? Y N If yes, how old is your present pair of lenses? _____
Type of contact lenses: _____ Rigid Soft Extended Wear Other Are they comfortable? Yes No

PAYMENT / CO-PAYMENT IS EXPECTED AT THE TIME OF SERVICE. THANK YOU!
I hereby authorize the release of any medical and/or other information necessary to process this claim. I also authorize my insurance benefits to be paid directly to the optometrist and understand that I will be financially responsible for any service not paid in full by my insurance Company.

SIGNED: _____ DATE: _____

Account will be settled today by: CHECK CASH CREDIT CARD INSURANCE

Doctor's Signature _____ DATE: _____

FAMILY HISTORY

Please note any family history (parents, grandparents, siblings, children, living or deceased) for the following conditions:

<u>DISEASE / CONDITION</u>				<u>RELATIONSHIP TO YOU</u>
Blindness	Y	N	?	_____
Cataract	Y	N	?	_____
Crossed Eyes	Y	N	?	_____
Glaucoma	Y	N	?	_____
Macular Degeneration	Y	N	?	_____
Retinal Detachment / Disease	Y	N	?	_____
Arthritis	Y	N	?	_____
Cancer	Y	N	?	_____
Diabetes	Y	N	?	_____
Heart Disease	Y	N	?	_____
High Blood Pressure	Y	N	?	_____
Kidney Disease	Y	N	?	_____
Lupus	Y	N	?	_____
Thyroid Disease	Y	N	?	_____
Other _____	Y	N	?	_____

SOCIAL HISTORY This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

____ **YES, I would prefer to discuss my Social History information with my doctor.**

Do you drive? Y N If yes, do you have visual difficulty when driving? Y N If yes, please describe: _____

Do you use Tobacco products? Y N If yes, type / amount / how long? _____

Do you drink alcohol? Y N If yes, type / amount / how long? _____

Do you use illegal drugs? Y N If yes, type / amount / how long? _____

Have you ever been exposed to or infected with: ____ Gonorrhea ____ Hepatitis ____ HIV ____ Syphilis

REVIEW OF SYSTEMS Do you currently, or have you ever had any problems in the following areas?

CONSTITUTIONAL

Fever, Weight Loss / Gain N Y ?

INTEGUMENTARY (Skin)

N Y ?

NEUROLOGICAL

Headaches N Y ?

Migraines N Y ?

Seizures N Y ?

EYES

Loss of Vision N Y ?

Blurred Vision N Y ?

Distorted Vision / Halos N Y ?

Loss of Side Vision N Y ?

Double Vision N Y ?

Dryness N Y ?

Mucous Discharge N Y ?

Redness N Y ?

Sandy or Gritty Feeling N Y ?

Itching N Y ?

Burning N Y ?

Foreign Body Sensation N Y ?

Excess Tearing / Watering N Y ?

Glare Light Sensitivity N Y ?

Eye Pain or Soreness N Y ?

Chronic Infection of Eye N Y ?

Sties or Chalazion N Y ?

Flashes / Floaters in Vision N Y ?

Tired Eyes N Y ?

ENDOCRINE

Thyroid / Other Glands N Y ?

EARS, NOSE, MOUTH, THROAT

Allergies / Hay Fever N Y ?

Sinus Congestion N Y ?

Runny Nose N Y ?

Post-Nasal Drip N Y ?

Chronic Cough N Y ?

Dry Throat / Mouth N Y ?

RESPIRATORY

Asthma N Y ?

Chronic Bronchitis N Y ?

Emphysema N Y ?

VASCULAR / CARDIOVASCULAR

Diabetes N Y ?

Heart Pain N Y ?

High Blood Pressure N Y ?

Vascular Disease N Y ?

GASTROINTESTINAL

Diarrhea N Y ?

Constipation N Y ?

GENITOURINARY

Genitals / Kidney / Bladder N Y ?

BONES / JOINTS / MUSCLES

Rheumatoid Arthritis N Y ?

Muscle Pain N Y ?

Joint Pain N Y ?

LYMPHATIC / HEMATOLOGIC

Anemia N Y ?

Bleeding Problems N Y ?

ALLERGIC / IMMUNOLOGIC

N Y ?

PSYCHIATRIC

N Y ?

If you answered YES to any of the above questions or have a condition not listed, please explain and list medications:

THANK YOU !!!!

Digital Retinal Screening

Our ability to view and record your internal eye health for future reference is now dramatically improved with our new Nidek Digital retinal Imaging System. Drs. Cline and Askew often see patients who have problems such as macular degeneration, diabetes, and glaucoma, which can lead to loss of vision. These conditions are most easily identified early by the use of retinal imaging, which serves as documentation of your present retinal eye health for future comparison. The Digital Retinal Image screening is fast, easy, and comfortable.

The Digital Imaging can be used in screening mode or in pathology-interpretation mode. The pathology-interpretation mode is used when Drs. Cline or Askew have identified a retinal abnormality, such as diabetic retinopathy, macular degeneration, or glaucoma. This is a more involved service, and the fee is \$80 if the more advanced level of imaging is done. If this is indicated, it will be discussed with you in advance.

The screening mode is used to document your current eye health status. It cannot be billed to your insurance company, but the fee is only \$20 for both eyes, total. The screening mode provides:

- ✓ A digital computerized map of the most important parts of the retina, including the macula.
- ✓ A digital view of your optic nerve heads, where conditions such as glaucoma show up first.
- ✓ The ability to show you your images today during your exam.
- ✓ A permanent record for you medical record file. This is very helpful for identifying future abnormalities.

Your insurance plan may provide you with eye exam coverage and coverage for pathology interpretation imaging services if you have a certain retinal or nerve abnormality, but it does not cover the Digital Retinal Image screening in healthy eyes.

Drs. Cline and Askew strongly recommend that all patients have a Digital Retinal Image screening annually. The additional fee is only \$20, and this fee is your personal responsibility. This will be done during your eye examination today, unless you choose to decline it.

_____ Yes, I accept the Digital Retinal Screening exam today.

_____ No, I decline the Digital Retinal Screening exam today.

Patient Name (Please Print) _____ DOB _____
Patient Signature _____ Date _____