

**Welcome to Oceanclear Eyecare**

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Age: \_\_\_\_\_ Sex: Male  Female  Other  | Status: Single  Married  Other

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_ Email Address: \_\_\_\_\_ Occupation: \_\_\_\_\_

**Reason for today's visit:** \_\_\_\_\_

When was your last eye exam: \_\_\_\_\_ Do you wear: Glasses  Contact Lenses

If you currently wear contact lenses, what brand do you wear: \_\_\_\_\_

**Health History**

Primary Care Physician: \_\_\_\_\_ Clinic: \_\_\_\_\_

Past Illness or Injuries: \_\_\_\_\_

Past Surgeries: \_\_\_\_\_

Current Medications: \_\_\_\_\_

Specific Allergies or Allergies to medications: \_\_\_\_\_

Are you pregnant and/or nursing Yes  No

**Social History**

Do you smoke? Yes  No  Former  If yes, how many packs/how long: \_\_\_\_\_

Do you drink alcohol? Yes  No  If yes, what is the frequency: \_\_\_\_\_

**Review of System (Mark all options that pertain to you)**

- **Eyes**

- |  |  |   |   |
|--|--|---|---|
| <input type="radio"/> Blurry Vision        | <input type="radio"/> Loss of Vision       | <input type="radio"/> Distorted Vision  | <input type="radio"/> Halos/Glares      |
| <input type="radio"/> Double Vision        | <input type="radio"/> Flashes/ Floaters    | <input type="radio"/> Mucous Discharges | <input type="radio"/> Redness           |
| <input type="radio"/> Sandy Gritty Feeling | <input type="radio"/> Tearing/Watering     | <input type="radio"/> Itchy             | <input type="radio"/> Dryness           |
| <input type="radio"/> Eye Pain             | <input type="radio"/> Sensitivity to Light | <input type="radio"/> Burning           | <input type="radio"/> Poor Night Vision |

- **Systematic**

- |   |  |  |   |
|---|--|--|---|
| <input type="radio"/> Headache            | <input type="radio"/> Migraine             | <input type="radio"/> Respiratory condition      | <input type="radio"/> Thyroid Condition |
| <input type="radio"/> High Blood Pressure | <input type="radio"/> Heart Diseases       | <input type="radio"/> Inflammatory Bowel Disease | <input type="radio"/> High Cholesterol  |
| <input type="radio"/> Sinus Congestions   | <input type="radio"/> Allergies/ Hay Fever | <input type="radio"/> Rheumatoid Arthritis       | <input type="radio"/> HIV/AIDS          |

Other: \_\_\_\_\_

**Self & Immediate Family History** (Please note which family member)

- Glaucoma    Self    Family: \_\_\_\_\_    Macular Degeneration    Self    Family: \_\_\_\_\_
- Lazy Eye    Self    Family: \_\_\_\_\_    Blindness    Self    Family: \_\_\_\_\_
- Cataract    Self    Family: \_\_\_\_\_    Retinal Detachment    Self    Family: \_\_\_\_\_
- Cancer    Self    Family: \_\_\_\_\_    Diabetes    Self    Family: \_\_\_\_\_

**Insurance Information**

Please provide information for Policy Holder/Subscriber only

Subscriber's Name: \_\_\_\_\_

Subscriber's Date of Birth: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address (If different than patient's): \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Policy/Member ID: \_\_\_\_\_

Group Number: \_\_\_\_\_ Employer: \_\_\_\_\_

How are you related to the policy holder/subscriber?    Self    Spouse    Child    Parent    Other

**For VSP only** – Last 4 Digits of Subscriber's Social Security Number: \_\_\_\_\_

**Assignment and Release: Insurance and Payment Information**

NOTICE: Insurance benefit verification does NOT guarantee payment or coverage. Although we do verify insurance coverage, insurance companies can and do give us incorrect information. We will only know the finalized co-pay once the claim has been sent and processed. **You are responsible for payment of deductibles, copays, non-covered services, and unpaid balances due to rejection of your claim by the insurance.**

I have read, understood, and agree to the "Assignment and Release" above and accept responsibility for all charges. I authorize use of this signature for all current and future insurance claims at this location, the release of necessary medical records to process claims, and payment to Oceanclear Eyecare for today and any future services.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Pupil Dilation Information**

If you are over 50, have certain symptoms, or this is your first eye exam with our doctor, dilation may be recommended to fully assess your eye health. The drops take 15–30 minutes to work. Without dilation, the doctor cannot fully examine the inside of your eyes. Common side effects include temporary blurry vision, especially near vision, for 2 to 4 hours and light sensitivity. We recommend arranging a driver if you are unsure how dilation will affect you.

**I have read and understood the above information. Signature:** \_\_\_\_\_

- I CAN have my eyes dilated today.
- I am NOT able to have my eyes dilated today/would like to reschedule dilation.
- I want to discuss with the doctor regarding dilation.
- I choose Optomap retinal photos for a \$39 copay - **no dilation needed if no findings of abnormalities.**