Waterford Lakes Eye Care

Dr. Vijay Nair

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Welcome to Waterford Lakes Eye Care. Please take a few moments to provide us with information about yourself, your health, and your visual needs so we can better serve you.

Last Name: _____First_____ M.I.____ Today's Date: _____

Preferred Name: _____ (Gender: □ M □ F) Occupation:_____

Marital Status: □ Single □ Married □ Divorced □ Widow Communication Preference: □ Email □ Phone □ Postal

Address: _____ Cell Phone: _____

City: _____ State: _____ Zip: _____ Work Phone: _____

Date of Birth: ____/____/____ Age: _____ SSN_____-_____-_____ Referred by: _____

Email (legible): _____ Parent/Guardian (if applicable) _____

Date of last eye exam: ____/____/____ Location and Doctor of last exam: _____

Preferred Language: □ English □ Spanish □ French □ Japanese

Race: □ American Indian □ Asian □ Black or African American □ Hispanic □ Native Hawaiian □ White

Ethnicity: □ Hispanic or Latino □ Native Hawaiian or other Pacific Islander □ Not Hispanic or Latino

Primary Care Physician: _____ Reason for today's visit: _____

Insurance Information

Vision Plan (Routine vision, glasses and contacts)

Primary's Name: _____ Primary's DOB: _____/_____/_____

Name of Plan or Insurance: _____ Primary's Employer: _____

Member ID or SSN Number: _____

Medical Insurance (Eye infections, injuries, glaucoma, etc)

Primary's Name: _____ Primary's DOB: _____/_____/_____

Name of Plan or Insurance: _____ Primary's Employer: _____

Member ID or SSN Number: _____ Group Number: _____

Eye History

Do you now wear glasses? □ YES □ NO If yes, how old are they? _____

How is your vision with them? _____ Are they comfortable? _____

What type? □ Readers □ Distance □ Bifocal □ Trifocal □ Progressive (no line bifocal)

Are you interested in contact lenses **OR** renewing your contact lens prescription?

□ Yes (***additional fees involved***) □ NO (no contact lens prescription exam done, only glasses exam)

***If you currently wear contacts and do not renew your prescription, you will NOT be able to order any more contacts without a contact lens renewal exam.**

What type and brand? _____ How many hours/day? _____

When do you replace them? _____ Are they comfortable? _____

Do you use a computer? □ YES □ NO How many hours per day? _____

Are you having any visual problems related to computer usage? _____

What Hobbies, activities, and/or sports do you enjoy**?** _____

Are **YOU** experiencing any of the following visual symptoms? (Check all that apply)

- □ Blurred Vision □ Light Sensitivity □ Loss of Night Vision
- □ Burning Eyes □ Itchy, Watery Eyes □ Reduced Side Vision
- □ Excessive Tearing □ Dry, Gritty Feeling □ Halos around Lights
- □ Noticeable Redness □ Pain or Discomfort □ Double Vision
- □ Old Floaters/Spots; how long and often _____
- □ Old Flashes or Flickers of light; how long and often _____
- □ New Floaters/Spots; how long and often _____
- □ New Flashes or Flickers of light; how long and often _____

Have **YOU** ever been diagnosed with, or treated for, any of the following ocular conditions?

- □ Retinal Detachment □ Eye Infections □ Lazy or Turned Eye
- □ Cataracts □ Glaucoma □ Styes, Inflamed Lids
- □ Macular Degeneration □ Disease of Retina

List any previous surgeries or injuries to your eyes:

_____

List eye medications: _____

Medical History

List allergies to medications:_____

List any prescription or OTC (over the counter) medicines:

_____

_____

Please list any previous injuries, surgeries, or hospitalizations: _____

_____

Are you pregnant or nursing? □ YES □ NO If pregnant, what is your due date: _____

Have **YOU** been diagnosed with or treated for any of the following problems? (Check all that apply)

Allergy	□ Food □ Other _____
Genitourinary	□ Bladder Infection □ Kidney Stones
Musculoskeletal	□ Arthritis □ Joint Pain □ Muscle Pain
Cranial/Facial	□ Dry Mouth □ Chronic Cough □ Sinus Infection □ Ear Infection □ Hearing Loss
Neurological	□ Headaches □ Migraines □ Seizures
Constitutional	□ Fever □ Weight Gain □ Weight Loss □ Dizziness/Fainting
Hematologic/Lymphatic	□ Anemia □ Clotting/ Bleeding Disorders
Psychiatric	□ Depression □ ADD/ADHD □ Alzheimer's/ Dementia
Gastrointestinal	□ Crohn's/IBS/Colitis □ Hepatitis □ Gall Bladder □ Ulcers
Immunologic	□ HIV/AIDS □ Syphilis □ Lupus □Mononucleosis □ Shingles
Respiratory	□ Asthma □ Chronic Bronchitis □ Emphysema, COPD □ Tuberculosis
Endocrine	□ Diabetes (how long)_____ years □ Thyroid Disease □ Elevated Cholesterol
Cardiovascular	□ High Blood Pressure □ Heart Problems
Other Conditions	_____

Family Medical History

In your **IMMEDIATE FAMILY**, is there any history of the following conditions?

□ Lazy or Turned Eye	Relationship: _____	□ Cataracts	Relationship: _____
□ Glaucoma	Relationship: _____	□ Macular Degeneration	Relationship: _____
□ Retinal Detach/Disease	Relationship: _____	□ Blindness (Cause?)	Relationship: _____
□ Other Eye Disease	Relationship: _____	□ Diabetes	Relationship: _____
□ High Blood Pressure	Relationship: _____	□ Heart Disease	Relationship: _____
□ Arthritis	Relationship: _____	□ Cancer	Relationship: _____
□ Kidney Disease	Relationship: _____	□ Lupus	Relationship: _____
□ Thyroid Disease	Relationship: _____		

Social History

Do you drive? □ YES □ NO — If YES, are you having any visual difficulties? _____

Do you use tobacco products? □ YES □ NO — If YES, how often? _____

Do you use alcohol? □ Yes □ NO — If YES, how often? _____

Do you have a history of drug or alcohol abuse? □ YES □ NO — If YES, how long? _____

Have you ever been exposed to HIV or other sexually transmitted diseases? □YES □ NO

Dilation Consent

For an optimal internal eye health evaluation, this office feels that most patients should have their eyes examined with the use of eye drops to dilate the pupils. Dilated pupils will cause the eyes to be light sensitive and the vision to be blurred especially for reading tasks. Driving may be difficult and should be done with extreme caution. Most patients will have no problem with the drops if they avoid reading and wear protective sunglasses for about four hours.

□ I agree to have my eyes dilated today.

□ I cannot have my eyes dilated today, but will reschedule this procedure at a later date.

□ I do not agree to have my eyes dilated.

HIPAA Notice and Acknowledgement

Notice is located on laminated page on clipboard

I acknowledge that I have been provided the HIPAA Notice of Privacy Practices □ Yes □ No

Acknowledgements and Signature

I acknowledge that the health and insurance information I have provided above is true and correct to the best of my ability. I authorize payment of any vision or medical benefits I may be eligible for directly to Waterford Lakes Eye Care. **I agree that if my employer, insurance carrier, or plan sponsor denies payment to all or any part of my claim, I will be financially responsible for all outstanding charges.** I acknowledge that authorization obtained at the time of service does not guarantee payment, and any services not covered by insurance will be billed to me. In the event that I incur any unpaid balances, I agree to pay any collection fees, reasonable attorney fees, filing fees, and any other unpaid balances associated with my account. I have read the conditions of service, and as the patient or the patient's authorized representative I hereby accept these terms.

All orders of eyewear are custom ordered. There are no refunds or exchanges.

Signature of patient or responsible party _____ **Date:** _____

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iWellnessExam™ (OCT) and Digital Retinal Imaging (DRI)

Sight threatening diseases such as glaucoma, macular degeneration, diabetic retinopathy and others often have **no outward signs or symptoms in early stages**, which is why eye exams, including a thorough retinal evaluation, are important to protect vision. Dr. Nair has incorporated the **iWellnessExam™ (OCT)** AND **Digital Retinal Imaging (DRI)** as part of our comprehensive eye exam in effort to provide patients with state of the art care, the latest technology and medical innovations thorough eye exam.
iWellnessExam™ (OCT) is like an **MRI** of the eye but taking only seconds to perform. This scan provides high definition **(3D)** cross sections of your retina and optic nerve which can reveal signs of disease in great detail that are invisible to traditional examination methods. **See laminated color copy of sample images.**

Digital Retinal Imaging (DRI) captures comprehensive digital images of the surface of the retina. It combines the technology of retinal photography and computerized digital imaging to produce remarkably clear retinal images. **See laminated color copy of sample images.**

Together these unique technologies can help detect potentially vision threatening and systemic diseases in their very early stages. They also provide your doctor with a permanent baseline record of your retinal examination for comparison during future exams.

Our technician will perform these two tests and Dr. Nair will review them with you during your examination. The charge for both tests is $39.00. The **$39.00** charge is typically **not** covered by your medical or vision insurance; therefore, the cost will be added separately in today's visit.

It is recommended by Dr. Nair that everyone has both tests done for the reasons mentioned in this form. He will personally review the images with you and answer any questions you have after his assessment of the images.

- □ I understand the vital importance of these tests and accept responsibility for the additional payment of $39 today.
- □ I decline these tests against medical recommendation.