

GRAY AREAS ARE ABOUT THE PATIENT

Please circle any that you have or are experiencing if none apply to you please leave blank.

OCULAR HISTORY: Flashing lights Floaters Itching Watering Burning
Crusting Glaucoma Cataracts Other: _____

MEDICAL HISTORY: High Blood Pressure Diabetes Headaches High Cholesterol Arthritis
Hyper/Hypothyroid Cancer Heart Disease Other: _____

SURGICAL HISTORY: Heart Brain Liver Spinal/Back Hysterectomy Full/Partial
Cataract Glaucoma Thyroid Other: _____

SOCIAL HISTORY (do you do any of the following): Smoke Drink Alcohol Abuse Drugs Use Illegal Drugs
(Have you ever had): A Blood Transfusion A Sexually Transmitted Disease

If anyone in your family has/had any of the following, **PLEASE WRITE BESIDE THE CONDITION WHO HAS/HAD THESE** (DAD, MOTHER, GRANDFATHER, GRANDMOTHER, AUNT, UNCLE, ETC.)

Diabetes _____ High Blood Pressure _____ Heart Disease _____
Cancer _____ Thyroid Disease _____ Cholesterol _____
Cataracts _____ Glaucoma _____ Macular Degeneration _____
Other _____

ALLERGY SYMPTOM CHECKLIST:

If you experience any of the following symptoms you may be suffering from Ocular Allergies, an easily treatable problem. Please circle the number that best describes how you feel.

	0=no problem	1=occasional problem	2=mild problem	3=moderate problem	4=severe problem	5=I am about to die
My eyes are red.....	0	1	2	3	4	5
My eyes itch.....	0	1	2	3	4	5
My eyes water.....	0	1	2	3	4	5
My eyes are crusty in the morning.....	0	1	2	3	4	5
My eyes swell overnight.....	0	1	2	3	4	5

DRY EYE SYMPTOM CHECKLIST

If you experience any of the following symptoms you may be suffering from Dry Eye Syndrome, an easily treatable problem. Please circle the number that best describes how you feel.

	0=no problem	1=occasional problem	2=mild problem	3=moderate problem	4=severe problem	5=I am about to die
My eyes feel gritty or sandy.....	0	1	2	3	4	5
My eyes burn.....	0	1	2	3	4	5
My eyes tear.....	0	1	2	3	4	5
My eyes are uncomfortable in windy conditions.....	0	1	2	3	4	5
My eyes are uncomfortable when the car A/C blows on them.....	0	1	2	3	4	5

READ CAREFULLY-VERY IMPORTANT

Insurance and Refraction Policy

We want your experience with Ford Vision Clinic to be as pleasant as possible and are happy to assist you with any insurance questions that you may have. Please read over the following. As a courtesy to our patients we will file insurance claims for all insurance plans in which we participate in. We are happy to file for you as long as you provide us with complete information prior to being seen by the Doctor. Failure to provide insurance cards-information before being called to exam room means that **YOU** are responsible for payment. Any charges not covered by your insurance are due at time of service unless other arrangements have been made ahead of time. You are responsible for any co-payments and deductible amounts or any non-covered services on the day services are rendered.

There are two types of insurance that cover eye care, Vision Insurance and Medical Insurance. Ford Vision Clinic must bill the appropriate insurance as legally directed. Vision Insurance covers your annual eye health exam (i.e. regular eye exams for glasses and contacts) when **NO** medical eye problem or related complaint specifically exists. Medical Insurance provides benefits for treatment of medical conditions related to the eye and/or health issues that can affect the eye. Symptoms or complaints such as eye disease, eye injury, or chronic medical condition (allergies) must be billed to medical insurance.

Although the examination that you received may be the same or similar to previous visits, the reason for the exam and the doctor's diagnosis dictate how we must bill our patients. If you have a medical concern such as cataracts, blurry or dry eyes, allergy or any medical diagnosis your **MEDICAL** insurance must be billed.

Refraction- a test generally used to determine your glasses or contact lens prescription. If you have a medical diagnosis, your visit must be billed to your medical insurance; unfortunately medical insurances DO NOT cover refractions. We are required by medical insurances to bill the patient for the service. As of November 2018 the fee for this service will be up to \$58 pending your insurance coverage.

I have read and understand the above policies of Ford Vision Clinic. Please indicate whether you agree or disagree.

___ Agree

___ Disagree

Signature: _____

Date: _____

DILATION CONSENT

It is our goal to provide a complete and thorough comprehensive eye examination. To effectively accomplish our goal, we feel it is important to dilate the pupils of your eyes. This will require placing drops in your eyes which will open the pupil and allow a better view of the inside of your eye.

As with many medications, there are some side effects of the drops used to dilate the pupil. These include sensitivity to light and blurred vision (in most cases the distance vision will be unaffected). The side effects usually last several hours but rarely last as long as 24 hours.

While we believe dilation is an important part of the eye examination process, we understand that some patients may wish to omit this procedure. There is no additional fee for this service. **Please indicate your preference below:**

I wish to be dilated today

I do not wish to be dilated and agree to hold Dr. Ford and Ford Vision Clinic harmless as a result of my actions.

Patient Signature Required: _____

Date: _____

Under 18 Guardian Signature Required: _____

Date: _____