Dr. Matthew G. Barber
THERAPEUTIC OPTOMETRIST
6224 Camp Bowie Blvd. Ft. Worth, TX 76116

Welcome To Our Office

Date: / / 2013

PERSONAL INFORMATION

Patient Name: Age: Mobile Phone:
Address: Date of Birth: Bus. Phone:
Employer: City: State: Zip:
Driver's License: S.S.# Occupation:
Name of Parent/Spouse: Have we seen other members of your family?
Pregnant: ❒yes ❒no Level/if student: School name:
How would you prefer to be contacted: ❒ Telephone ❒ Postage ❒ Email: Do you smoke: ❒yes ❒no Height: Weight:

MEDICAL & VISUAL HISTORY

CHIEF VISUAL COMPLAINT: ❒Poor Distance Vision ❒Poor Near Vision ❒Other

Name of Physician & City: Address/phone #:
Name of last Eye Doctor & City: Address/phone#:
Please list any *medical condition you are being treated for & how long*:
Please list any *medications you are taking* (including hormones, birth control, non-prescription):
Please list any *allergies to medications*: When was your last eye exam?
Please list any pertinent past surgical history:

Please check any medical conditions that apply to you (Review of Systems).

ALLERGIES:
❒ _____

CARDIOVASCULAR/VASCULAR:
❒Diabetes
❒High Blood Pressure
❒Vascular Disease

CONSTITUTIONAL:
❒**Fever, Weight Loss/Gain**

ENDOCRINE:
❒Thyroid
❒Other Glands

GASTROINTESTINAL:
❒Diarrhea
❒Constipation

GENITOURINARY:
❒Genitals/Kidney/Bladder

HEAD:
❒Injury/Trauma
❒Bleeding Problems

HEMATOLOGIC/LYMPHATIC:
❒Anemia/Bleeding disorders

IMMUNOLOGIC:
❒ _____

INTEGUMENTARY (skin):
❒ _____

MUSCULOSKELETAL:
❒Muscles/Joints/Tendons/Ligaments/Nerves

NEUROLOGICAL:
❒Headaches/Migraines
❒Seizures

PSYCHIATRIC:
❒ _____

RESPIRATORY:
❒Asthma
❒Chronic Bronchitis
❒Emphysema

❒**Other, please list:** _____

Please check all of the Symptoms of Conditions that apply to you.

❒Blurred Vision
❒Double Vision
❒Dry Eye(s)
❒Itching Eye(s)
❒Lazy Eye
❒Red Eye(s)
❒Sandy, Gritty Feeling
❒Burning, Stinging Eye(s)
❒Tearing
❒Glaucoma
❒Bumps on Lids
❒Cataracts
❒Retinal Problems
❒Painful Eye(s)
❒Blind Eye
❒Crossed Eye(s)
❒Glare / Light Sensitive
❒Swollen Eye(s)
❒Mattering/Discharge
❒Other _____
Current Eye Medications: _____
Eye Surgery / Injury in past: _____

Please check Conditions that are present in *other family members*.
❒Cataracts ❒Glaucoma ❒Diabetes ❒Heart Disease ❒High Blood Pressure ❒Macular Degeneration
❒Other Eye Diseases: _____
❒Other Inherited Conditions: _____

CONTACT LENS HISTORY

❒ *I would like to know my contact lens options.*
❒ *Last time I wore contacts:*
❒ *I am not interested in contacts.*
❒ Problems with contacts
❒ *I have never worn contacts.*

❒Daily Wear
❒Rigid Gas Perm.
❒Solutions Used: _____
❒Extended Wear
❒Bifocal
❒Disposable / Frequent Replacement
❒Other: _____

ARE YOU INTERESTED IN INFORMATION ABOUT LASER EYE SURGERY? ❒Yes ❒No

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ACTIVITIES & INTERESTS

❒Football/Contact Sports ❒Baseball / Softball ❒Basketball / Volleyball ❒Water Sports
❒Dusty Work Environment ❒ *I work with computers_____hours/day.* ❒Soccer ❒Other Hobbies/Activities_____

HOW DID YOU FIND OUT ABOUT OUR OFFICE?

❒Mail Outs ❒Phone Book ❒Gift Certificate ❒Location ❒Media ❒Other:_____
❒Insurance ❒☺ Direct Referral - Name:_____

DILATION

Dr. Barber strongly recommends that all patients receive a dilated eye examination every year. A dilated eye examination allows the doctor to evaluate the health of the retina and the inside of the eye. This aids the doctor in determining diseases such as macular degeneration, glaucoma, diabetic retinopathy, retinal holes and tears, cataracts, and tumors of the eyes.
The cost of dilation is $20. Please select one of the following boxes below.

ONLY CHECK ONE

❒ I **AGREE** to have my eyes dilated today and understand the importance of an annual dilated exam.

❒ I **DO NOT** wish to have my eyes dilated today. And, I release Dr. Matthew Barber from any liabilities related to the failure to treat or diagnose any eye conditions due to the lack of diagnostic information which could have been obtained by these tests.

VISUAL FIELD TESTING

Dr. Barber recommends that all patients receive a Visual Field screening test. Visual Field testing is a quick procedure that measures a patient's peripheral and central vision. This type of testing provides the Doctor with a computerized map of your Visual Field. It helps the Doctor in the early detection and treatment of many eye diseases such as **Glaucoma** and **Macular Degeneration**. By mapping out the Visual Field, the doctor can also determine if there has been some type of vascular accident such as **Stroke** or **Brain Damage**, even interruption of visual communication due to **Tumors**. **The Visual Field Screening test is $15.** Please select one of the following boxes below.

ONLY CHECK ONE

❒ I **AGREE** to this procedure and understand the importance of a Visual Field Screening test.

❒ I **DO NOT** wish to have the Visual Field Screening test. And, I release Dr. Matthew Barber from any liabilities related to the failure to treat or diagnose any eye conditions due to the lack of diagnostic information which could have been obtained by these tests.

Eye Screen RETINAL PHOTOGRAPHY

We are pleased to provide our patients with an advanced digital retinal exam called Eye Screen. Eye Screen is a high resolution screening photograph of your retina which will help us document, review, and compare your retina over time. We will use the Eye Screen photo to document a baseline image of your optic nerve, macular area, and main blood vessels that provide your retina with oxygen. This retinal image will allow Dr. Barber to screen for eye diseases and improve our ability to view your internal retinal health at a much higher resolution than traditional slit lamp or ophthalmoscope. **The Eye Screen photograph is $30.** Please select one of the following boxes below.

ONLY CHECK ONE

❒ I **AGREE** to have my retinal health evaluated with the Eye Screen retinal camera.

❒ I **DO NOT** wish to have the Retinal Photographic Exam. I understand that I will still have a thorough eye examination with slit lamp observation.

INSURANCE RELEASE, PAYMENT RESPONSIBILITY AND PRIVACY POLICY

I hereby authorize the physician to release any information required to process this claim. I also authorize my insurance benefits be paid directly to the physician, and I understand I am financially responsible for non-covered services and possible fees associated with collecting unpaid balances. I have read and understand the Privacy Policy of this office (the Privacy Policy is available online at www.fortworthtso.com in its entirety).

_____ _____
Patient Signature (or guardian) Date

THANK YOU FOR ENTRUSTING US WITH YOUR EYECARE