

Full Name: _____ Preferred Name: _____ Sex: Male Female
 Mailing Address: _____ City: _____ State: _____ Zip: _____
 Preferred Language _____ Race: _____ Ethnicity: _____ Birth Date: _____
 Email Address: _____ Last 4 of SSN: _____
 Cell Phone: _____ Home Phone: _____ Work Phone: _____
 What is your preferred method of communication? Email Mail Telephone May we send you text message alerts? Yes No
 Employer/ School: _____ Occupation/ Grade: _____

Who may we thank for referring you to our office? _____ If not referred, how did you hear about our office: Insurance Internet Walk-in Location Doctor: _____ Other: _____
 Emergency Contact: _____ Relationship: _____ Phone Number: _____
 What is the reason for today's visit? Red Eye Dry Eye Itchy Eye Blurry Vision Floaters Glasses Contact Lenses Other

VISION INSURANCE	MEDICAL INSURANCE
Insurance Company: _____	Insurance Company: _____
ID #: _____	ID #: _____
Subscriber: _____	Subscriber: _____
DOB: ____/____/____ Last 4 Of SSN # _____	DOB: ____/____/____ Last 4 Of SSN # _____
Relationship: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent/Guardian <input type="checkbox"/> Other	Relationship: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent/Guardian <input type="checkbox"/> Other

DIGITAL RETINAL IMAGES (DRI)

DR. SPAETH RECOMMENDS THAT ALL PATIENTS HAVE AN IMAGE TAKEN DURING THEIR EYE EXAM.

- Dr. Spaeth recommends having the Digital Retinal Image or dilation of the eyes.
- Enhanced view of your retina, vessels and optic nerve to evaluate your health.
- Early detection of **Glaucoma, Macular Degeneration, Diabetes, and Arteriosclerosis.**
- The image becomes a part of your permanent record.

THE FEE FOR THIS PROCEDURE IS \$39.00 FOR BOTH EYES

- Yes, I would like to have digital retinal images taken for my records.
 No, I decline to have digital retinal imaging

OCULAR HISTORY

Date of Last Eye Examination: _____ Previous Eye Doctor: _____
 Do you wear glasses? Yes No If yes, how old is your present pair of lenses? _____
 Do you wear contact lenses? Yes No If yes, what type? Disposable Rigid Soft Toric Multifocal
 How often do you discard your contact lenses? Daily Weekly 2-3 Weeks Monthly Quarterly
 Do you drive? Yes No Do you have difficulty seeing when driving? Yes No
 Are there any problems with your current glasses or contact lenses? _____
 What other services are you interested in? LASIK Computer Glasses Reading Glasses Prescription Sunglasses Driving Glasses

Please note if you have any of the following:

<input type="checkbox"/> Strabismus (Eye Turn)	<input type="checkbox"/> Keratoconus	Have you had surgery for any of the following?
<input type="checkbox"/> Diabetic Retinopathy	<input type="checkbox"/> Dry Eye	<input type="checkbox"/> Cataract <input type="checkbox"/> Right Eye <input type="checkbox"/> Left Eye
<input type="checkbox"/> Retinal Detachment	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Retinal Detachment <input type="checkbox"/> Right Eye <input type="checkbox"/> Left Eye
<input type="checkbox"/> Amblyopia (Lazy Eye)	<input type="checkbox"/> Optic Nerve Disease	<input type="checkbox"/> Trauma <input type="checkbox"/> Right Eye <input type="checkbox"/> Left Eye
<input type="checkbox"/> Retinal Disease	<input type="checkbox"/> Macular Degeneration	<input type="checkbox"/> Laser Vision Correction <input type="checkbox"/> Right Eye <input type="checkbox"/> Left Eye
		<input type="checkbox"/> Other (please list): _____

MEDICAL HISTORY

Please list any medications you are currently taking (including eye drops, oral contraceptives, aspirin, over the counter medications): _____
 Are you allergic to any medications? If yes, which ones: _____
 List any recent surgeries and/or hospitalizations you have had: _____

FAMILY HISTORY Please note any family history (parents, grandparents, siblings; living or deceased) for the following conditions

	Relation to You		Relation to You
<input type="checkbox"/> Blindness	_____	<input type="checkbox"/> Cancer	_____
<input type="checkbox"/> Cataracts	_____	<input type="checkbox"/> Diabetes	_____
<input type="checkbox"/> Strabismus (Eye Turn)	_____	<input type="checkbox"/> Heart Diabetes	_____
<input type="checkbox"/> Glaucoma	_____	<input type="checkbox"/> High Blood Pressure	_____
<input type="checkbox"/> Macular Degeneration	_____	<input type="checkbox"/> Kidney Disease	_____
<input type="checkbox"/> Retinal Detachment	_____	<input type="checkbox"/> Lupus	_____
<input type="checkbox"/> Arthritis	_____	<input type="checkbox"/> Thyroid Disease	_____

REVIEW OF SYSTEMS

Do you currently, or have you ever had problems in the following areas:

Eyes (Ocular Symptoms)

- Eye pain or soreness
- Fatigue/ Tired Eyes
- Dry/ Gritty feeling
- Redness
- Burning
- Itching
- Excess Watering
- Discharge
- Foreign Body Sensation
- Chronic Infections
- Squinting
- Glare/Light Sensitivity
- Halos around Lights
- Double Vision
- Loss of Vision
- Blurred Vision
- Flashes
- Floaters
- Stye

Cancer

Type: _____

Cardiovascular/Vascular

- Heart Disease
- High Blood Pressure
- High Cholesterol
- Stroke

Constitutional

- Fever
- Weight Gain or Loss

Ear, Nose, Throat, Mouth

- Allergies/ Hay Fever
- Sinus Infections
- Hearing Loss

Genitourinary

- Genitals/Kidney/Bladder

Endocrine

- Thyroid
- Diabetes
- Chronic Fatigue
- Anemia
- Bleeding Disorder
- Lupus

Neurological

- Headaches
- Seizures
- Alzheimer's
- Parkinson's
- Multiple Sclerosis

Gastrointestinal

- Acid Reflux
- IBS/ Crohn's Disease
- Liver/ Spleen Problems
- Ulcers

Musculoskeletal

- Rheumatoid arthritis
- Muscle/Joint Pain

Psychiatric

- Anxiety
- Depression
- Hallucinations

Respiratory

- Asthma
- Chronic Bronchitis
- Emphysema

Skin

- Rosacea
- Allergic Reactions
- Easy Bruising

If you checked any of the above boxes or have a condition not listed, please explain further: _____

ASSIGNMENT AND RELEASE

Please sign below for authorization of payment for contracted insurance plans and the release of any medical information necessary for your insurance company in conjunction with federal privacy laws. Our office will provide you with a thorough receipt for reimbursement of non-contracted insurance plans.

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose health information in order to treat you, obtain payment for our services, and conduct healthcare operations involving our office. The Notice of Privacy Practices you have been given describes these uses and disclosures in detail. **I acknowledge that I have received a copy of the office's Notice of Privacy Practices**

By signing below you acknowledge that you accept responsibility for payment of our services and materials you receive. Payment for professional services is expected at the time services are provided. We accept cash, check, Visa, MasterCard, American Express and Discover. Our policy regarding orders for materials is that we require a minimum of a 50% deposit at the time the order is placed and balance due upon delivery. All professional services are non-refundable. All material returns are subject to a 20% restocking fee.

Signature: _____ Date: _____

FOR OFFICE USE ONLY

<input type="checkbox"/> EX	<input type="checkbox"/> CTL EX	<input type="checkbox"/> CTL CHECK	<input type="checkbox"/> WEARING CTL	<input type="checkbox"/> OFFICE VISIT	<input type="checkbox"/> EMERGENCY OFFICE VISIT
NOTES FOR EXAM:	CONTACTS: CURRENTLY WEARING: BC: OD: BC: OS: TRIAL LENSES: BC: OD: BC: OS:		GLASSES: Discussed: 1 ST PAIR A/R: <input type="checkbox"/> SV: <input type="checkbox"/> PROG: <input type="checkbox"/> BF: <input type="checkbox"/> RX SUN: <input type="checkbox"/> 2 ND PAIR A/R: <input type="checkbox"/> SV: <input type="checkbox"/> PROG: <input type="checkbox"/> BF: <input type="checkbox"/> RX SUN: <input type="checkbox"/> CRT/ NVF A/R: <input type="checkbox"/> SV: <input type="checkbox"/> PROG: <input type="checkbox"/> BF: <input type="checkbox"/>		
	<input type="checkbox"/> ORDER TRIALS <input type="checkbox"/> ORDER CTLS <input type="checkbox"/> 1 WK F/U <input type="checkbox"/> OTHER _____		<input type="checkbox"/> ARMD <input type="checkbox"/> GLAUCOMA FOLLOW-UP: _____ <input type="checkbox"/> DRY EYE <input type="checkbox"/> DIABETES <input type="checkbox"/> LASIK <input type="checkbox"/> BLEPHARITIS MEDICAL INS.: _____ <input type="checkbox"/> RED EYE <input type="checkbox"/> OTHER _____ <input type="checkbox"/> DR. SPAETH <input type="checkbox"/> BILLING		