Welcome to Charlotte Optometric Clinic, P.A.

NAME: _____ *D.O.B:*_____
*AGE:*_____ *RACE:*_____*SEX: M F*
*ADDRESS:*_____
_____
(STREET) *(CITY)* *(STATE)* *(ZIP)*
*HOME PHONE:*_____*CELL*
*PHONE:*_____
*EMAIL ADDRESS:*_____ *IF*
*STUDENT: GRADE*_____
EMPLOYER:
_____*OCCUPATION:*_____
_____
CURRENT
*MEDICATIONS:*_____
_____
_____
____
ALLERIGY TO
MEDICATIONS:_____
_____
DO YOU: DRINK ALCOHOL: YES NO USE TOBACCO PRODUCTS: YES NO

What is the main reason for today's exam?
_____
Past Illnesses or Injuries: _____*Past Surgeries*:
_____
Do you wear glasses and/or contacts? If yes what type:
_____

Interview - Comprehensive

Eye Conditions: *Have you ever been diagnosed with any of the following conditions?*

Cataract:	**No**	**Yes**	**If Yes,**	**left**	**right**	**both**	
Age-related Macular Degeneration:		**No**	**Yes**	**If Yes,**	**left**	**right**	**both**
Glaucoma:	**No**	**Yes**	**If Yes,**	**left**	**right**	**both**	
Diabetes:	**No**	**Yes**	**If Yes,**	**Stable**		**Mild**	**Moderate. Last A1C value? _____**
Diabetic Retinopathy:	**No**	**Yes**	**If Yes,**	**left**	**right**	**both**	
Dry Eye:		**No**	**Yes**	**If Yes,**	**left**	**right**	**both**
Eye infection, inflammation, or allergy:		**No**	**Yes**	**If Yes,**	**left**	**right**	**both**
Floaters and/or flashes of light:		**No**	**Yes**	**If Yes,**	**left**	**right**	**both**
Iritis or Uveitis:		**No**	**Yes**	**If Yes,**	**left**	**right**	**both**
Retina defects or degenerations:		**No**	**Yes**	**If Yes,**	**left**	**right**	**both**

Eye Concerns: *Are you having any of the following eye concerns?*

Redness:	**No**	**Yes**	**If Yes,**	**left**	**right**	**both**
Burning:	**No**	**Yes**	**If Yes,**	**left**	**right**	**both**
Itching:	**No**	**Yes**	**If Yes,**	**left**	**right**	**both**
Tearing:	**No**	**Yes**	**If Yes,**	**left**	**right**	**both**
Discharge:	**No**	**Yes**	**If Yes,**	**left**	**right**	**both**

Vision Concerns: *Are you having any of the following vision concerns?*

Blurred Vision:	**No**	**Yes**	**If Yes,**	**left**	**right**	**both**
Eyestrain:	**No**	**Yes**	**If Yes,**	**left**	**right**	**both**
Eye Pain:	**No**	**Yes**	**If Yes,**	**left**	**right**	**both**
Severe sensitivity of lights:	**No**	**Yes**	**If Yes,**	**left**	**right**	**both**
Headache:	**No**	**Yes**	**If Yes,**	**Forehead**	**Back**	**Temple**
Poor night vision:	**No**	**Yes**	**If Yes,**	**left**	**right**	**both**
Bothersome night glare:	**No**	**Yes**	**If Yes,**	**left**	**right**	**both**
Double vision:	**No**	**Yes**	**If Yes,**	**left**	**right**	**both**
Total loss of vision:	**No**	**Yes**	**If Yes,**	**left**	**right**	**both**

RECEIPT OF NOTICE OF PRIVACY POLICES & CONSENT/ ACKNOWLEDGMENT OF INSURANCE POLICIE

I have been given the opportunity to receive and review the Notice of Privacy Practices. (Available at front desk) I have read and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations. I authorize the same to assignment of benefits from my insurance company. In addition, I accept financial responsibility for any unpaid balances not covered by my vision service provider, in addition to any co-payments due upon receipt of services.

SIGNATURE_____DATE_____

PLEASE TURN OVER

OCULAR	**FAMILY**	**MEDICAL**	SELF	FAMILY	**MEDICAL**	SELF	FAMILY
BLINDNESS(From Disease)	**Y N**	ALLERGIC DISORDER	Y N	Y N	HEART DISEASE	Y N	Y N
CATARACTS	**Y N**	ARTHRITIS	Y N	Y N	HIGH BLOOD PRESSURE	Y N	Y N
DIABETIC RETINOPATHY	**Y N**	ASTHMA	Y N	Y N	HIGH CHOLESTEROL	Y N	Y N
GLAUCOMA	**Y N**	CANCER	Y N	Y N	LUNG DISEASE	Y N	Y N
LASIK/ LASER SURGERY	**Y N**	DERMATOLIGIC DISORDER	Y N	Y N	MIGRAINE HEADACHES	Y N	Y N
LAZY EYE/CROSSED EYE	**Y N**	DEPRESSION	Y N	Y N	STROKE	Y N	Y N
MACULAR DEGENERATION	**Y N**	DIABETES TYPE ( )	Y N	Y N	VASCULAR DISORDER	Y N	Y N
RETINAL DETACHMENT	**Y N**	EPILEPSY	Y N	Y N	WEIGHT GAIN/ LOSS	Y N	Y N

HAVE YOU OR ANY OF YOUR FAMILY MEMBERS HAD ANY OF THE FOLLOWING? (PLEASE CIRCLE)

Retinal Health Screening Tests

Retinal examination allows the doctor to thoroughly examine the inside of your eyes for signs of disease. We do this by dilating the eyes with drops or taking retinal images with a camera. Dilation **is included** in the exam fee or your insurance copay. The cost for Retinal Imaging is an additional **$25.00** that insurance **does not** cover.

This examination is important in the early detection of disorders which may be harmful to your vision, including Glaucoma, Hypertension, Diabetes, and Macular Degeneration.

RETINAL IMAGING $25 **Or** **DILATION: COVERED BY INSURANCE (SIDE EFFECTS)**

No light sensitivity
No stinging
No blurry vision

Blurry Near Vision for 4-6 hours
Light sensitivity

Please choose one of the following and sign below.

- ***I PREFER DILATION DROPS.***
- ***I PREFER RETINAL IMAGING ($25.00).***
- ***I PREFER NOT TO HAVE DILATION OR RETINAL IMAGING.***

Signature _____Date _____

CONTACT LENS FITTING AGREEMENT (IF APPLICABLE)-

YOU MUST HAVE A CONTACT LENS FITTING EVERY YEAR TO RENEW YOUR CONTACT PRESCRIPTION.

Contact lenses are medical devices that require through testing ensuring accuracy and safety. By law, contact lens fittings are required annually to keep your prescription active. After your initial visual assessment and health exam, the doctor can discuss contact lens options with you.

Our contact lens fitting session includes:

- Evaluation of lenses on your eyes to ensure proper fit and optimal vision
- Trial lenses of your new prescription
- Initial care kit including new case and solution
- Follow-up visits 30-days from the initial exam to ensure successful fitting
- Insertion and removal technique training for first time wearers

The contact lens fitting fee is **NON-REFUNDABLE**. Contact lenses are to be purchased separately.

The fees are as follows:

A) New Contact Lens Wearer Fitting- $95 B) Annual Evaluation and Fitting of Contact Lenses- $75

I ACKNOWLEDGE THIS AGREEMENT, AND I AGREE TO PAY THE ABOVE CHARGES TODAY AND RETURN FOR ANY NECESSARY FOLLOW-UPS TO FINALIZE MY RX.

Signature _____
Date_____