MAXTON VISION GROUP
COME SEE CLEARLY

Welcome to our office!

Patient name: _____ Patient's date of birth: _____

Parent/Guardian name: _____ Parent's date of birth: _____

Mailing address:_____

City: _____ State: _____ Zip code: _____

Phone numbers: Cell: _____ Work: _____ extension_____

Our office uses text messaging to confirm future appointments and to notify patients of their pickups. Standard text-messaging rates may apply with your carrier.

□ **OK** □ **No**, I would like to opt out of text messaging. Call me instead.

Email address:_____

Reason(s) for today's visit: □ Routine vision care □ Glasses □ Contact lenses □ Red eye/Office visit

□ Other:_____

Insurance: Please present all insurance information prior to your examination.

Vision Insurance: _____ Ins ID#_____

Medical Insurance: _____ Ins ID#_____

Primary Cardholder's Name: □ Self _____

Relationship to patient: □Spouse/Significant other □Parent/Guardian

Primary cardholder's SSN: _____ Primary cardholder's DOB: _____

Vision care plans only cover routine vision exams along with eyeglasses and contact lenses. Medical insurance plans must be used if you have any eye health problems or systemic health problems that has ocular complications. If you have both types of insurance plans, it may be necessary for us to bill some services to one plan and other services to the other. This is to minimize your out-of-pocket expenses. I have read and agree with these policies.

Signature: _____ Today's Date_____

Authorization: I, the undersigned, certify that I (or my dependent) have insurance coverage(s) with the above listed insurance company(s) and assign directly to Julie K. Ly, OD & Associates (dba Maxton Vision Group) all insurance benefits, if any, and otherwise payable to me for services rendered. **I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE.** I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature: _____ Today's Date_____

Name:

PERSONAL health history:

- Date of last Eye exam: _____ Date of last Physical exam: _____
- Female patients: are you pregnant? □ No □ Yes, # of months: _____
- Social history:
  - Do you drink alcohol? Amount/frequency: _____
  - Do you use tobacco products? Amount/frequency: _____
  - Recreational drugs (including synthetic weed)? Amount/frequency: _____
- Drug allergies/hypersensitivities:_____

Eye History (Please check all that applies, currently and in the past)

- □Eye pain/soreness □Fatigue/Tired eyes □Dry/gritty feeling □Redness □Burning/Stinging □Itching
  □Watery eyes □Blurry vision □Double vision □Floating spots □Flashing lights □Eye infection □Eye injury
  □Cataracts □Glaucoma □Macular degeneration □Retinal detachment □Keratoconus □Bell's Palsy
  □Eye surgery_____ □Eye drops used currently: _____

General Health History (Please check all that applies and list medications)

□Asthma □Chronic Bronchitis □Emphysema □Medications: _____
□Cancer, Type: _____ □In Remission □Medications: _____
□Diabetes □Pre-diabetic □Type I (Childhood-insulin dependent) □Type II (late onset)
□Diet/exercise—no meds □Medications: _____
□High blood pressure □ Medications: _____
□High cholesterol □ Medications: _____
□HIV + / AIDs: Last T-cell count_____ □Medications:_____
□Migraines □ Headaches: Frequency_____ □Medications: _____
□Seizures: Frequency_____ □Medications: _____
□Hypothyroid □Hyperthyroid □Medications: _____
□Acid Reflux □Heart burn □Medications: _____
□Arthritis, Type: _____ □Medications: _____
□Anxiety □Depression □ADD □ADHD Medications: _____
□Polycystic Ovarian syndrome (PCOS) Medications: _____
□Other health problems: _____
□Other current medications:

FAMILY health history:

□Asthma □Cataracts □Diabetes □High blood pressure □High Cholesterol □Thyroid problems
□Migraines/Headaches □Macular degeneration, list family member(s)_____
□Retinal detachment, family member(s)_____ □Glaucoma, family member(s)_____
□Keratoconus, list family member(s)_____ □Cancer, list type:_____
□Other:_____

Permission to Release Information: Please list the names(s) of people that we may contact and share information with regarding your health and private information (if any):

Name: _____ Relationship: _____ Phone #_____

Name: _____ Relationship: _____ Phone #_____

In an event of an emergency, who may we contact on your behalf (other than 911)?

Name: _____ Relationship: _____ Phone #_____

Name: _____ Relationship: _____ Phone #_____

Name:

Retinal Evaluation

A retinal exam is required. This checks for any holes, tears, retinal detachment, macular degeneration, bleeding, glaucoma and other diseases that can impact your vision, including Hypertension, Diabetes, High Cholesterol and Cancer.

□ Drops will be used to dilate (or open) the pupils to allow a thorough evaluation of the health of the retina and other structures in the back of the eye. Your eyes will become blurry for 3-4 hours, and you will be provided with some temporary sunshades to help with light sensitivity.

□ Take retinal photos instead. There are no side effects with this option, and the photos become a valuable part of your chart for comparison of progression of diseases or changes to the back of the eyes. This comes highly recommended by your eyecare team as a screening tool. **The fee is $39.**

Signature: _____ Date:_____

Visual field screening (automated machine):

Visual field screening can detect areas of missing vision in both the central and peripheral vision. The test can show early symptoms of various medical conditions such as glaucoma, stroke, brain tumors, macular degeneration, diabetes, high blood pressure, and other neurological problems. It can also help monitor changes caused by some medications. If the screening is abnormal, the doctor will request for a more detailed visual field to map out the exact areas of vision loss. **The fee is $29.** □ yes □ no

Signature: _____ Date: _____

□ **For a reduced fee of $60, I would like both Retinal Photos and a Visual Field screening for a more detailed exam.**

Signature: _____ Date: _____

Federal Health Insurance Portability & Accountability Act (HIPAA)

I acknowledge that I have received and/or reviewed a copy of the HIPAA Privacy Practices (see bottom form).

Signature: _____ Date:_____