DIAMOND VISION OPTOMETRY, INC.

Date ____________________

NAME Mr/Mrs/Ms ______________ (first) ______________ (last) ______________ Date of Birth ______________ Age ______

Guardian (if applicable) ______________________________ Occupation ______________________

Address ______________________________ City ______________ State ______ Zip ______

Phone ______________________ Work ______________________ Cell ______________________

Email ______________________________________ Ethnicity ______________________

Emergency Contact ______________________________________ Phone ______________________

Last Eye Exam ______________________ Last Medical Exam ______________________

Name of Medical Doctor ______________________________________ Phone ______________________

Medical Insurance ____

Primary Subscriber ______________________ SS# __________ Birthdate __________ Relationship __________

Vision Insurance ____

Primary Subscriber ______________________ SS# __________ Birthdate __________ Relationship __________

PATIENT'S OCULAR/ MEDICAL HISTORY

Do you have any allergies to medications? ____Yes ____No If yes, please list ______________________
List all the medications you take ____
List all the major injuries, surgeries, and /or hospitalization you have had ______________________
Are you pregnant and/or nursing? ____Yes ____No
Do you wear glasses? ____Yes ____No If yes, how old is your current pair of glasses? __________
Type of glasses ______________________ What do you like about your glasses? __________
Do you wear contact lenses? ____Yes ____No If yes, how old is your current pair of lenses? __________
Type of contact lenses ______________________ What do you like about your contacts? __________

Please check any conditions that you have or have had in the past:

- ☐Blurred Vision
- ☐Loss of Vision
- ☐Double Vision
- ☐Crossed/Lazy Eyes
- ☐Flashes/Floaters
- ☐Eye Surgery
- ☐Cataract
- ☐Retinal Detachment
- ☐Macular Degeneration
- ☐Glaucoma
- ☐Pain
- ☐Excessive Tearing
- ☐Dryness
- ☐Itching/Burning
- ☐Eye Infection/Redness
- ☐Eye Injuries
- ☐Diabetes
- ☐High Blood Pressure
- ☐High Cholesterol
- ☐Heart Disease
- ☐Headache
- ☐Migraine
- ☐Stroke
- ☐Thyroid
- ☐Arthritis
- ☐Thyroid Disease
- ☐Lupus
- ☐Cancer
- ☐Asthma
- ☐Lung Disease
- ☐Other ______________________
____

SOCIAL HISTORY

This and all other information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

Do you drive? ____YES ____NO If you have visual difficulty when driving, describe ______________________
Do you use tobacco products? ____YES ____NO (If yes) type/ amount/ how long: ______________________
Do you drink alcohol? ____YES ____NO (If yes) type/ amount/ how long: ______________________
Do you use recreational drugs? ____YES ____NO (If yes) type/ amount/ how long: ______________________
Have you ever been exposed to or infected with: ____Gonorrhea ____ Hepatitis ____HIV ____Syphilis

FAMILY HEALTH HISTORY

Please check any conditions that apply to your immediate family members:

- ☐Blindness
- ☐Cataract
- ☐Crossed/Lazy Eyes
- ☐Glaucoma
- ☐Macular Degeneration
- ☐Retinal Detachment
- ☐Arthritis
- ☐Cancer
- ☐Diabetes
- ☐Heart Disease
- ☐High Blood Pressure
- ☐Kidney Disease
- ☐Lupus
- ☐Thyroid Disease
- ☐Other ____________________

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HOW DID YOU HEAR ABOUT US? ____

ACKNOWLEDGEMENT OF RECEIPT

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 this health information in order to treat you, to obtain payment for our services, and to 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 the *Notice of Privacy Practices* from Diamond Vision Optometry, Inc.

____ ____________________

Patient's Signature or Legal Guardian **Date**

If signing as a personal representative, describe relationship to the patient and the source of authority to sign this form:

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DILATION CONSENT

Dilated fundus examination is performed by optometrists and ophthalmologists as a routine part of an eye examination. It is a diagnostic procedure that employs the use of mydriatic eye drops to enlarge the pupil in order to obtain a better view of the fundus of the eye. Dilation has been found to be a more effective method for evaluation of internal ocular health, observing the retina more completely to rule out maladies such as glaucoma, retinal detachment, cataracts, eye tumors, and other sight or life threatening conditions. These eye drops require about twenty minute's time to fully dilate the pupil. We always prefer to have our patients driven after their dilation, as the eye drops may cause blurred vision and light sensitivity for up to six hours.
Please note, you will be made aware if your insurance plan does not cover this procedure.
Please check one:

______YES, I give permission to the doctor to perform dilation today.

______ NO, I choose not to have dilation done. I understand that an exam of the retina through a dilated pupil is necessary to detect conditions that would otherwise be unobservable. These conditions, if undetected, may lead to partial of total vision loss.

______I prefer to schedule dilation to be done in the near future.

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I authorize the eye doctor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my dependent during the period of such eye care to third parties payers and /or health practitioners.
I authorize my insurance company to pay directly to **Diamond Vision Optometry, Inc.**
I understand that my insurance carrier may not cover some services and products and benefit information does not constitute approval of payment. Deductible and fees not paid by my insurance carrier will be my sole responsibility. I also understand that there will be no refunds for rendered professional medical services related to eye exams or contact lens fitting or evaluations.
I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

____ ____________________

Patient's Signature or Legal Guardian **Date**

____ ____________________

Doctor's Signature **Date**