Welcome to Hickory Creek Eye Care & Decatur Eye Site!

Patient Information

Patient Name _____ Today's Date _____

DOB _____ Age _____ ☐Male ☐Female Email Address _____

Address _____ Cell Phone _____

Apt # _____ City _____ Home Phone _____

State _____ Zip Code _____ Fax _____

Primary Care Physician _____ Phone _____

Previous Eye Doctor _____ Phone _____

Last Eye Exam _____ Referred By _____

Emergency Contact _____ Phone _____

☐No Insurance

Vision Insurance Information

Name of Insurance _____ ID # _____

Name of Cardholder _____ DOB _____

Relationship to Cardholder: ☐child ☐spouse ☐other

Cardholder address _____

City _____ State _____ Zip Code _____

Patient History

Occupation _____ Employer _____

Hobbies/Sports _____

☐ I wear glasses ☐ I wear contact lenses ☐soft ☐ hard Brand of Contacts _____

OFFICE USE ONLY

DFE _____Yes ____No

PHOTO _____Yes ____No

Patient #_____

IOP

OD_____

OS_____

Brand Name Trial CL_____

OD_____

OS_____

SPHERE_____ **TORIC**_____ **RGP**_____ **MULTIFOCAL-MONO**_____

OCULAR HISTORY

- ☐ PRK/RK
- ☐ Lasik
- ☐ Cataract Surgery
- ☐ Ocular Surgery (strabismus)
- ☐ Pterygium Surgery
- ☐ Other Surgery_____

_____

_____

MEDICATIONS

1._____

2._____

3._____

4._____

MEDICATION ALLERGIES

_____

General Surgery/Injury_____

☐ Doesn't Drive ☐ Drives ☐ Doesn't use Tobacco ☐ Uses Tobacco

Driving Difficulties | Type/Amt/How long?

☐ Doesn't Drink Alcohol ☐ Drinks Alcohol ☐ Doesn't use Illegal Drugs ☐ Uses Illegal Drugs

Type/Amt/How long? | Type/Amt/ How long?

☐ Currently Pregnant ☐ Nursing

EYES
- ☐ Vision Loss
- ☐ Blurry Vision
- ☐ Double Vision
- ☐ Dryness
- ☐ Redness
- ☐ Mucous Discharge
- ☐ Gritty Feeling
- ☐ Itching
- ☐ Burning
- ☐ Excess Watering
- ☐ Light Sensitivity
- ☐ Eye Pain/Soreness
- ☐ Chronic Infection
- ☐ Stye
- ☐ Flashes
- ☐ Floating Spots
- ☐ Tired Eyes
- ☐ Cataracts
- ☐ Diabetic Retinopathy
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Retinal Detachment

GASTROINTESTINAL
- ☐ Colitis
- ☐ Crohn's Disease
- ☐ Ulcers
- ☐ Constipation
- ☐ Diarrhea

CONSTITUTIONAL
- ☐ Fever
- ☐ Weight Loss/Gain
- ☐ Fatigue
- ☐ Trauma

GENITOURINARY
- ☐ STD's
- ☐ Kidney Problems
- ☐ Bladder Problems

INTEGUMENTARY (SKIN)
- ☐ Eczema
- ☐ Rosacea
- ☐ Psoriasis

NEUROLOGIC
- ☐ Headaches
- ☐ Migraines
- ☐ Seizures
- ☐ Mult. Sclerosis

ENDOCHRINE
- ☐ Non Insulin Diabetes
- ☐ Insulin Diabetes
- ☐ Thyroid Dysfunction
- ☐ Hormonal Dysfunction

RESPIRATORY
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema

CARDIOVASCULAR
- ☐ Heart Disease
- ☐ Hypertension
- ☐ High Cholesterol

EAR/NOSE/THROAT
- ☐ Allergies
- ☐ Sinus Congestion
- ☐ Runy Nose
- ☐ Post Nasal Drip
- ☐ Chronic Cough
- ☐ Dry Throat/Mouth

ALLERGIC/IMMUNE
- ☐ Drug Allergies
- ☐ Seasonal Allergies
- ☐ Lupus
- ☐ Arthritis

LUMPH/HEMATOLOGIC
- ☐ Anemia
- ☐ Bleeding Problems
- ☐ Leukemia

MUSCULOSKELETAL
- ☐ Fibromyalgia
- ☐ Muscular Distrophy
- ☐ Osteoarthritis
- ☐ Ankylosing Spond

Family Medical History: Note relation to yourself in the box (Mother, Paternal Grandfather). Review of Systems. Please check all that apply to you.

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

Appointment Sign-In

As part of the complete care for your eyes, our doctor will check to make sure your eyes are healthy with Dilation or the images from the Retinal Photographic Exam (Retinal Imaging), The optometrist will be able to check for signs of Glaucoma, Diabetic changes, Macular Degeneration and Holes. For these reasons, our doctors want every patient to either have their eyes dilated or do the Retinal Photographic.

When you choose the Retinal Photographic, we take images, which are stored digitally and are easily reviewed from year to year. There are no side-effects and it only takes a couple of minutes.

When you choose dilation instead of Retinal Photographic, dilating eye drops will be used to expand your pupils. The dilating drops will make your vision blurry up close for 3 to 6 hours.

Please let us know, in which way, you would like to have the overall health of your eyes examined:

_____ Dilation

_____ Retinal Photographic

Financial Responsibility

To our patient with Medical and/or Vision benefits: We will be happy to file your insurance claims forms or take assignment of your medical/vision benefits as designated by the Plan(s) of which you state you are member. We will do all we can to help you receive the maximum benefits. However, in the event that the plan sponsor determines you are not eligible for the date of service, or makes a determination that you are eligible for a reduced level of coverage, by signing this statement you hereby agree to be financially responsible for any and all charges incurred by you and not paid by the sponsor.

Print Patient Name _____ Age_____

Patient Signature (if over age 18)_____ Date_____

If the patient is under 18 year of age, please complete the box below, then, sign and date:

Parent/Guardian Name _____

Relationship to patient: ____ Parent ____ Legal Guardian _____ Other

Parent/Guardian Signature_____

Acknowledgement of Receipt of Notice of Privacy Practices

I, the Patient/Parent or Legal Guardian, have received a copy of this office's Notice of Privacy Practices.

_____

Printed Name of Patient/Parent or Legal Guardian Date

_____

Signature of Patient/Parent or Legal Guardian Date