Eyes on Sunrise ***Welcome to our office!***

Last Name	First Name		MI
Street Address			
City	State		Zip
DOB	AGE	M/F	SS#
Daytime Phone	Cell Phone		
Facsimile:	Email:		
Occupation:	Employer:		
How did you learn of Dr. Nick:			
Primary Physician Name:	Physician Phone:		Last Physical:
When was your last eye exam?	Doctor:		

Reason for today's visit:

O Annual Eye Examination
O Laser Vision Correction Consult
O Contact Lenses
O Eye Injury, Irritation, or Disease
O Other _____

Current Vision Correction: O None O Glasses O Contact Lenses

Are you interested in learning more about contact lenses? O Yes O No

PATIENT MEDICAL HISTORY:

Diabetes	O Yes	O No	Eye Surgery	O Yes	O No
High Blood Pressure	O Yes	O No	Glaucoma	O Yes	O No
Skin Disorders	O Yes	O No	Psychiatric	O Yes	O No
Heart Conditions	O Yes	O No	HIV/AIDS	O Yes	O No
Respiratory Problems	O Yes	O No	Cancer	O Yes	O No
Cholesterol	O Yes	O No	Thyroid	O Yes	O No

List ALL current medications:

Do you have any allergies to ANY medications: O Yes O No If yes, list below:

Do you drive? O Yes O No

Are you pregnant/nursing? O Yes O No

Contact in case of emergency:

Name: _____ Relationship: _____

Contact Phone Number: _____

If patient is a minor, please complete the following:

Guardian: _____ Relationship: _____

Guardian Phone Number: _____

Vision Insurance Information:

Insurance Company: _____ Name of Insured:_____

Relationship to Insured (Self/Spouse/Dependent): _____

Insurance Plan ID#: _____ Is your insurance in a group plan? ☐ Yes ☐ No

If insurance is a group plan (yes), what is the Employer or Group Name? _____

How will you settle your account today? ☐ Cash ☐ Check ☐ Credit Card ☐ Debit Card

Family Medical History (mother, father, sibling, etc.)

Blindness: _____ Heart Disease: _____

Glaucoma: _____ Cancer: _____

Diabetes: _____ Other: _____

Social History:

This information is kept strictly confidential. You may discuss this portion with the doctor if you prefer. This information is important for medical purposes as well as compliance with insurance directives.

Would you prefer to discuss your social history directly with the doctor? ☐ Yes ☐ No

Do you use tobacco products? ☐ Yes ☐ No If yes, how many packs/day? _____

Do you drink alcohol? ☐ Yes ☐ No If yes, how many drinks/day? _____

Do you use any recreational drugs? ☐ Yes ☐ No If yes, which type? _____

Patient

What is your primary form of vision correction? ☐ Glasses ☐ Contacts ☐ None

What are the occasions when you do NOT want to wear your glasses?

Sports: _____ Physical Fitness: _____ Hobbies: _____ Business: _____

Other: _____

If you wear contact lenses, what type: ☐ Soft ☐ Rigid ☐ Not sure ☐ Does not apply

What is it about your contact lenses that you would like to improve? (i.e. end of day comfort, dryness, vision, etc.)

_____

Do you experience (check those that apply:

☐ Burning	☐ Nausea	☐Blurry vision
☐ Itchiness	☐ Headaches	☐ Glare or reflections
☐ Redness	☐ Double vision	☐ Flashes of light
☐ Dryness	☐ Fainting	☐ Floating spots
☐ Watery Eyes	☐ Dizziness	☐ Trouble seeing at night
☐ Gritty feeling	☐ Eye Strain	☐ Sensitivity to light

Visual Needs

Do you (check those that apply)…

☐ Work on the computer for long periods of time?	☐ Ever find a need for prescription sunglasses?
☐ Have only one pair of glasses?	☐ Have problems with glare or reflections (ex: night driving)
☐ Want information on thinner, lighter lenses?	☐ Require safety glasses?
☐ Wear bifocals?	☐ Participate in sports? Which ones? _____
☐ Want information on "no lline" bifocals?	☐ Want more information about LASER VISION CORRECTION?
☐ Spend a lot of time outdoors?	☐ Want more information on Non-Surgical alternatives to LASIK?

Acknowledgement of Receipt of Notice of Privacy Practices

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 Eyes on Sunrise, Dr. Nicholas Rashid.

Signature _____

If you are signing as a personal representative of the patient, please describe your relationship to the patient.

Relationship to Patient _____ Print Name _____

Financial Responsibility Statement

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any materials or professional services rendered. I certify that all information given is true and correct to the best of my knowledge. I will notify you of any changes in my status.

I request that payment of authorized insurance benefits or medicare be made either to me or on my behalf to EYES ON SUNRISE for any devices or professional services rendered to me. I authorize any holder of medical information about me to release to the health care financing administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Professional fees are due when services are rendered unless prior arrangements are made. A deposit of 50% is required towards the total cost of glasses or contact lenses before an order can be placed. The remaining balance is due at the time of dispensing. When eye glasses are purchased through insurance, the balance is due in full when the order is placed. If contact lenses are being shipped, payment in full is required before an order is placed.

Signature _____

If you are signing as a personal representative of the patient, please describe your relationship to the patient.

Relationship to Patient _____ Print Name _____

OPTOMAP AND DILATION OF THE EYES

DILATION of the pupils is an important component of every comprehensive eye examination. It allows your doctor to detect many eye diseases, including glaucoma, macular degeneration, and cataracts. Additionally, illnesses such as high blood pressure and diabetes can be detected during a thorough evaluation of eye structures. Our office now has **OPTOMAP**, which does a complete retinal image **WITHOUT DILATION. This technology is $39 additional with or without insurance.**

If you choose **OPTOMAP**, the doctor will have a complete retinal image without using drops. If you choose to have your eyes dilated, most patients experience only very mild side effects from the medications used to dilate your pupils. These side effects include short-term blurring of your near vision and increased sensitivity to light. These effects usually last 3-6 hours. **The most thorough exam will be to choose BOTH OMPTOMAP and dilation.**

Refusal to have your pupils dilated may cause your doctor to be unable to detect certain diseases. Please choose one:

_____ Yes, I would like to have **OPTOMAP AND** my eyes dilated at this visit ($39)

_____ Yes, I would like to have **OPTOMAP, but NO** dilation at this visit ($39)

_____ Yes, I would like to have my eyes dilated, but **NO OPTOMAP** at this visit

_____ No, I do not want **OPTOMAP or to be dilated** at this time

_____ _____ _____

Print Name of Patient Signature of Patient Date