LAKE POINT VISION *8185 Highway 242, Conroe TX 77385*
Dr. Oanh Le Dr. Jizhao Yang *Office (*936)-703-2310 *Fax (936) 703-2311*

WELCOME TO OUR OFFICE

Mr./Mrs./Ms./Dr. _____ _____ _____ Date: _____
First Name Middle Last Name

Address: _____ City:_____

State:_____ Zip:_____ Occupation:_____

Date of Birth:_____ Age:_____ Sex: M F E-mail:_____

Home Phone: _____Work Phone: _____ Cell Phone: _____

Method of Payment: Cash Credit Card (we do NOT accept check) **Insurance:**

Insurance Agreement: I hereby authorize this vision care provider to apply for benefits in my behalf for covered service by them.

I also assign my benefit and request all payment from my insurance directly to my vision care provider.

I authorize this vision care provider to release to the insurance company any information related to this or any related item.

I agree to the responsibility of full payment pending any remaining balance that is not covered by the insurance company.

*If, **within 90 days** of the initial office visit, the doctor or staff believes that an additional office visit will be necessary to recheck the prescription, then this additional visit will be scheduled at no additional charge.* ***Re-check visits after 90 days*** *WILL be charged an additional refraction fee.*

GENERAL HEALTH HISTORY:

Date of Last Physical: _____ If applicable, are you pregnant? Yes or No If yes, how long_____
Medications:_____
Drug Allergies:_____
HIV Positive (if yes, please notify doctor only)

(**Please check Y = yes, N = no, or F = family**)	Y	N	F
Headache / Migraines			
Thyroid Problems			
Cancer			
Asthma			
Heart Problems			
Diabetes			
Cholesterol			
Hypertension			
Other (please specify):			

GENERAL EYE HISTORY:

Reason for today's visit: Glasses Contact Lenses Other _____
Last Eye Exam Date: _____
How did you hear about us? Postcard Referral

Have you ever worn contact lenses? Yes No

If yes, please fill out the information below:

How's comfort? _____

Previous Contact Lenses brand_____ Replacement: 1 Day 2 Weeks 1 Month 1 Year

Power: Right Eye _____ Left Eye _____ Sleep-in contact lenses? Yes No

How old are contact lenses?_____Average wearing time: _____

How's vision?_____Solution used:_____

(**Please check Y = yes, N = no, or F = family**)	Y	N	F
Blurred Distance Vision			
Blurred Near Vision			
Double Vision			
Burning or Itching			
Retinal Detachment			
Macular Degeneration			
Glaucoma			
Cataract			
Floaters			
Light Flashes			
Eye Injury / Eye Surgery			
Other (please specify):			

PUPIL DILATION: I agree to dilation (*No Additional Cost*) Yes No Discuss with Doctor

Pupil dilation allows the doctor to examine the retina (back of the eye). Dilation can detect many conditions within the eye that may not be detected during a routine eye exam. Dilation is strongly recommended for individuals with a history of **diabetes, glaucoma, cataract, high nearsightedness, high blood pressure, sudden change in vision,** or any conditions that affect the integrity of the retina. Side effects are sensitivity to light that lasts 4-6 hours and trouble focusing up close for 2-3 hours.

VISUAL FIELD TEST: I agree to a visual field screening ($20.00) Yes No Discuss with Doctor

This test checks for loss of sight in your peripheral and central vision possibly due to glaucoma, cataracts, macular degeneration, retinal detachments, and/or neurological diseases. The doctor highly recommends a visual field exam especially if you have a history of **headaches, migraines, flashes floaters, a sudden change of vision, or a family history of glaucoma.**

OPTOMAP: I agree to Optomap photos ($35.00) Yes No Discuss with Doctor

The **Daytona Plus Optomap is the LATEST ultra-wide field retinal imaging machine**. It's a unique technology that captures more than 80% of your retina in one panoramic image while traditional imaging method typically only show 15% of your retina at one time.

The doctor strongly recommends Optomap. While eye exams generally include a look at the front of the eye to evaluate health and prescription changes, a thorough screening of the retina is critical to verify that your eye is healthy. It can lead to early detection of common diseases, such as **Glaucoma, Diabetes, High Blood Pressure, Macular Degeneration, Bleeding** in the retina and even **Cancer**. This is a quick test, painless, and does NOT require dilation drops.

Acknowledgement of the Federal HIPPA Privacy Practices

I acknowledge that I have received and/or read a copy of the Notice of Privacy Practices.

Signature: _____ Date: _____

(Parent or guardian must sign if patient is a minor)