Hometown Eye Care

Name: _____ Gender: ____M ____F Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____ SSN: _____ Single ___ Married ___ Widow___

Occupation/Employer: _____ Work Phone: _____

Vision Insurance: _____ Policy Holder Name & DOB: _____

Health Insurance: _____ Policy Holder Name & DOB: _____

Have you ever been to this office before? Yes No Date of last Eye Examination: _____

Eye Health/History: (Please check all that apply)

Do any of these diagnoses apply to you or your family members?

Yourself	(Circle all the apply)	**Family**
Yes | No	Cataracts	Yes | No
Yes | No	Dry Eye	Yes | No
Yes | No	Lazy eye/ Amblyopia	Yes | No
Yes | No	Glaucoma	Yes | No
Yes | No	Macular degeneration	Yes | No
Yes | No	Corneal Dystrophy	Yes | No
Yes | No	Melanoma of the Eye	Yes | No
Yes | No	Retinitis Pigmentosa	Yes | No
Yes l No	Retinal Detachment	Yes l No

Referred By: _____

Emergency Contact Info.:

Name: _____

Phone #: _____

History of eye Surgeries: Yes or No if yes please list

_____

Other Eye Health/History: _____

_____

_____

_____

Medical History: _____

__Hypertension __Migraines

__High Cholesterol __Multiple Sclerosis

__Hearing Loss __Rheumatoid Arthritis

__Diabetes Type 1 __Lupus

__Diabetes Type 2 __Sjogren's Disease

__Heart Disease __HIV/AIDS

__Stroke __Shingles

__Anxiety __ Depression

__Thyroid Disease Other _____

__Asthma/COPD _____

_____

List of Medications & Eye Drops:

_____

_____

_____

_____

_____

_____

Pharmacy: _____

Yes | No Currently Pregnant or Nursing

Yes | No Smoke Tobacco, Packs Per day _____

Yes | No Consume Alcohol, Drinks per week _____

Primary Care Provider _____ **Last Physical** _____

Are you **allergic** to any medications? __*Yes* __*No* If yes, please list: _____

Have you ever had an eye injury, surgery, or bad infection? ***Yes No*** If yes, explain: _____

Are there any other conditions we should know about? ___*Yes* ___*No* Explain: _____

Hometown Eye Care
HIPAA Privacy

I acknowledge and agree that I have been informed that this office abides by the HIPAA laws and am entitled to a copy of the Notice of Privacy Practices for review and, if desired, to keep my records on the date identified below.

I understand that Hometown Eye Care may use & disclose necessary personal health information (for example, my name, address, subscriber identification number, eye exam information, and/or type of products provided) to another party to permit Hometown Eye Care to perform its administrative duties, provide me with eye care services and products, process my vision/medical benefits claims and communicate with me regarding vision care services/products provided by Hometown Eye Care (for example, text messaging & emails of exam reminders or information about services/products provided by Hometown Eye Care).

I can be assured that Hometown Eye Care does not sell my personal health information of any kind to a third party for such a party's own use. I authorize Hometown Eye Care to submit my vision/medical benefits claims to my plan sponsor or health plan to receive reimbursement directly for the vision services and products that I have received from Hometown Eye Care.

X_____

Patient Signature or Patient's Parent/Guardian *Date*

I authorize Hometown Eye Care to release my complete medical records and other documentation made by Dr. Quesada or personnel for the entire time I was treated by Hometown Eye Care to the following family members, friends, or other caregivers who contact Hometown Eye Care for the purposes of providing them with information related to treatment and/or payment obligations:

Name:_____ **Relationship:**_____

Name:_____ **Relationship:**_____

Informed Consent or Refusal for a Dilated Fundus Exam

The Florida Board of Optometry requires that a comprehensive eye exam includes a dilated fundus exam. This is accomplished by placing drops in your eyes that make the pupils become larger. The purpose of enlarging the pupils is to enhance the detection of any ocular diseases such as cataracts, glaucoma, retinal disease, malignant growth, and retinal detachment; all of which can lead to vision loss. In addition, some systemic conditions such as diabetes and hypertension can cause changes in the health of the eye and can be detected by dilation. Possible side effects (these side effects typically do not last longer than 4-6 hours): Blurry vision at near and light sensitivity

Please Check One:

___ I understand the above and consent to ***have dilation done today***.

___ I understand the above and ***decline dilation at this time***.

Patient/Parent/Guardian Signature:_____ **Date:**_____

Digital Retinal Photography Consent Form

Screening digital retinal photography is not covered by many vision/medical insurance plans. There is a ***$25 fee*** (includes both eyes) for the procedure. Once the photos have been taken the doctor will share the results with you.

___Yes, I consent to retinal photos, viewing, & discussing the findings during my exam

___No, I do NOT consent to retinal photos. I understand that there will not be a photographic record of my current internal eye health.

X_____**Date:** _____

Patient Signature or Patient's Legal Representative

Review of Symptoms

This is to help us with your concerns for ***THIS VISIT***

Patient Name:_____ **Date:**_____

What do you most want to discuss today?_____

Please Circle Yes Or No:

General

Fatigue	Yes	No
Chills/Fever	Yes	No
Night Sweats	Yes	No
Weight Loss	Yes	No

Respiratory

Shortness of Breath	Yes	No
Cough	Yes	No
Wheezing	Yes	No

Cardiovascular

Chest Pain	Yes	No
Palpitations	Yes	No

Endocrinology

Increase thirst or hunger	Yes	No
Unexplained weight change	Yes	No
Heat/ Cold Intolerance	Yes	No

Psychiatric

Anxiety	Yes	No
Irritability	Yes	No
Depression	Yes	No
Concerns about your emotional/physical safety?	Yes	No

Gastrointestinal

Abdominal Pain	Yes	No
Constipation	Yes	No
Diarrhea	Yes	No
Heartburn	Yes	No
Nausea/Vomiting	Yes	No

Skin

Rashes	Yes	No
Itching	Yes	No
Mole Changes	Yes	No

Musculoskeletal

Joint Pain	Yes	No
Muscle Aches	Yes	No
Leg Swelling	Yes	No

Neurologic

Headaches	Yes	No
Dizziness	Yes	No
Difficulty Walking	Yes	No
Numbness/Tingling	Yes	No

Eyes, Ears, Nose & Throat

Hearing Loss	Yes	No
Sore Throat	Yes	No
Blurred Vision	Yes	No
Halos/Glare	Yes	No
Double Vision	Yes	No
Flashes/Floaters	Yes	No
Dryness	Yes	No
Tearing	Yes	No
Sandy Gritty feeling	Yes	No
Itching	Yes	No
Burning	Yes	No
Redness	Yes	No
Discharge	Yes	No

Other _____

Any Changes in Medications, Since Last Visit?

_____

_____

_____

Insurance / Medicare/ Self Pay Release

I authorize the release of any information required to process an insurance claim. I understand that I am responsible for payment of any amounts not covered by my insurance plan. By signing below, I submit all health information disclosed is accurate. I authorize Hometown Eye Care to receive insurance payments directly for the services I have received. **If you do not have vision or medical insurance, this will be considered self-pay & services must be paid on the date of service.**

X_____**Date:** _____

Patient Signature or Patient's Legal Representative

FOR OFFICE USE ONLY: **Medications Reviewed:** ☐ **Drug Allergies Reviewed:** ☐