REAL VISION CENTER

Date: _____

Appt Time: _____

LAST NAME_____ FIRST NAME_____ M.I._____
ADDRESS _____ CITY _____ST_____ ZIP_____
CELL PHONE _____ WORK PHONE _____ SS# _____
OCCUPATION _____ EMPLOYER _____
DATE OF BIRTH _____ EMERGENCY CONTACT _____ PHONE_____
EMAIL_____REFERRED BY _____
MEDICAL INSURANCE _____ POLICY# _____
VISION INSURANCE _____ POLICY # _____
PRIMARY DOCTOR _____ PHONE _____LAST EXAM_____
PREVIOUS EYE DOCTOR _____PHONE _____ LAST EXAM _____
REASON FOR VISIT _____
MEDICATIONS _____
DRUG ALLERGIES_____
ARE YOU INTERESTED IN LASIK? YES NO

Ocular History (Check off any current conditions you suffer from)

__Headaches	__Dryness	__Infection of Eye or Lid	__Sandy or Gritty Feeling	__Double Vision
__Glare/Light Sensitivity	__Watery Eyes	__Itching	__Strabismus (crossed eye)	__Floaters or Spots
__Tired Eyes	__Eye Pain/Soreness	__Mucous Discharge	__Blurred Vision Distance	__Loss of Vision
__Amblyopia (lazy eye)	__Glaucoma	__Drooping eyelid(s)	__Blurred Vision Near	__Loss of Side Vision
__Burning	__Cataracts	__Redness	__Haloes	__Retinal Detachment

Medical History (Check off any conditions you suffer from)

__High Blood Pressure	__Diabetes	__HIV or AIDS	__Frequent Headaches
__High Cholesterol	__Asthma	__Heart Problems	__Pregnant/Nursing
__Thyroid Problems	__Stroke	__Sinus Problems	__Cancer

Family Medical History (Check off any conditions you suffer from)

__High Blood Pressure	__Glaucoma	__Blindness	__Cancer
__High Cholesterol	__Diabetes	__Macular Degeneration	__Other: _____

Dilation of the pupils involves instilling eye drops that may make your vision blurry and or sensitive to light for 2-6 hours. Dilation allows the doctor to fully evaluate the health of your eyes, assisting in the early detection of many disorders, including Glaucoma, Cataracts, Macular Degeneration, Hypertensive Retinopathy, Diabetic Retinopathy and Cancer.

_____ I agree to have eyes dilated _____ I do not agree to have eyes dilated _____ I refuse dilation today but will reschedule.

HIPAA

I have read and understand the Health Information and Patient Privacy Act (HIPPA). I hereby allow Magdalena Saint Louis, O.D., P.A. to send and/or receive any and all documents necessary for the proper diagnosis and/or treatment of my medical condition.

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with the above mentioned insurance and assign all benefits directly to Maddalena Saint Louis, O.D., P.A. I understand that I am responsible for all co-pays and/or charges not paid by insurance. I hereby authorize Maddalena Saint Louis O.D., P.A. to release all information necessary to secure payment of benefits and authorize the use of my signature for all insurance submissions.

_____ _____

Responsible Party Date