Berry Eyecare and Optical

Name as it appears on your insurance card (pretty please) ☺

(Last)_____(First)_____(MI)___Nickname:_____Date:_____

Address:_____City_____ST____Zip_____

Home:_____Daytime:_____Cell:_____DOB:_____Age:_____

SSN:_____employer:_____occupation:_____marital status:____

Today's visit is for: ( ) glasses ( ) contacts ( ) routine ()other_____

_____E-Mail:_____

Previous patient: yes/no, if no, how did you hear about our office:_____

Date of last eye examination:_____Doctor's name:_____

If under 18, person responsible:_____address(if different from above):_____

MEDICAL HISTORY

Do you have any of the following?		Do your blood relatives have any of the following?	
Diabetes	yes/no	Glaucoma	yes/no
Glaucoma	yes/no	Age Related Macular Degeneration	yes/no
Age Related Macular Degeneration	yes/no	Eye Cancers	yes/no
Past eye surgeries	yes/no	Are you taking any medications or eye drops? Yes/no	
High Blood Pressure	yes/no	list:_____	
History of eye cancer	yes/no	Do you have any allergies to any eye drops? Yes/no	
Cataracts	yes/no		
Strabismus (cross eyed?)	yes/no	Do you wear contact lenses? yes/no if so, for how many	
Thyroid disease	yes/no	Do you smoke? Yes/no, if so, how much?_____	
Use computers a lot?	yes/no	Do you drink alcohol? Yes/no if yes, how much?_____	

Name of primary care physician:_____

phone #:_____

please explain any medical conditions:_____

DILATION

We simply instill drops into your eyes in order to dilate the pupil. The vast majority of the retina is not visible without dilation. Important diseases can and will be missed without dilation. Dilation is especially important for patients with Diabetes, High Myopia, Reduced vision, age greater than 50, first eye exam ever, glaucoma or family history of glaucoma, and age related macular degeneration. Because your vision will be blurry, you must be extremely cautious driving in the few hours following pupil dilation. Call our office immediately if you experience any dizziness, nausea, pain, or unusual visual disturbances within 12 hours of pupil dilation.

Yes I want my eyes dilated. I am aware of the risks and benefits mentioned above.

No I do not want my eyes dilated. I am aware that potentially sight threatening diseases might be missed and I waive all liability towards the Doctor for this decision.

PERIPHERAL VISION TESTING

This instrument checks for loss of sight, both in central and peripheral areas. This can assist us in early detection of glaucoma, retinal problems, and some neurological diseases.

Yes I do consent to having a Visual Field test performed.

No I do not wish to have this test performed. I am aware that potentially sight threatening diseases might be missed and I waive all liability towards the Doctor for this decision.

I agree that I have been given access to Berry Eyecare and Optical Notice of Privacy Practices/HIPPA Policies. Written copies are available at my request. I agree to pay all applicable exam charges, even if my insurance company does not. I also authorize release of any information necessary to process my insurance claim and assign and request payment directly to my physician.

Signature:_____Date:_____