Walden Eye Care *Registration and Health History*

Date: _____

Name: (Last) _____ (M) _____ (First) _____ (Nickname) _____

Address _____ City _____ State _____ Zip _____

Hm. Phone: _____ Mobile. Phone: _____ DOB: _____ SS #: _____

IF USING INSURANCE TO PAY FOR ANY PART OF TODAY'S VISIT PLEASE SPECIFY BELOW

Vision / Medical Insurance : _____ Supplement: _____

What is your reason for today's visit? _____

Are you interested in new glasses today? Yes / No

Are you interested in contacts today? Yes / No Are you a current contact lens wearer? Yes / No

Are you interested in sunglasses today? Yes / No

** Women Only* Are you currently Pregnant? Yes / No ….. Nursing? Yes / No*

Any hobbies or tasks you perform that you would like a different pair of glasses for? Yes / No ;
If Yes above, please describe: _____
Have you ever had an eye injury or surgery? Yes / No if yes, please describe it below:
_____
Do you currently take any **eye** medications? Yes / No If yes, please list: _____

Do you have any allergies to medications? Yes / No if yes, please list below:

_____ _____ _____ _____

Dilation

Dilation of the pupils allows the doctor to obtain a more thorough view of the retina. Therefore, it is **highly** recommended that the pupils be dilated. The procedure entails using eye drops that will increase your pupil size. The most common side effects include sensitivity to light, decreased near vision and glare. It will take anywhere from 15-30 minutes for your pupils to dilate and side effects will last anywhere from 2-4 hours. If you choose to be dilated, it may help to wear your sunglasses after leaving the office. Any retinal problems that are not found should you choose **not** to be dilated, will **not** be the doctor's responsibility. The doctor will be happy to discuss dilation with you during your exam.

I understand the importance of dilation and _____ I do _____ I don't want my eyes dilated

Authorization and Release

Your insurance is a method for you to receive reimbursement for fees you have paid to the optometrist for the services rendered. Having insurance is not a substitute for payment. Many companies have fixed allowances or percentages based on your contract with them not with our office. It is **your** responsibility to pay in advance for the deductible, coinsurance, or any other balances not paid by your insurance. 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 benefits or the benefits payable for related services. This assignment will remain in effect until revoked in writing. A photocopy of this assignment is considered to be valid as the original. By signing this statement, you agree to be financially responsible for all charges.

---> Patient or Parent/Guardian Signature _____

HIPAA Policy

I have been made aware of this office's HIPAA privacy policy and a copy of it was provided to me

---> Signature _____

Turn this Page Over ------>

Personal Medical History :

Please check ALL conditions for which you are being treated , or take medications for.

Constitutional:
__*Developmental Disabilities*
__*Cancer*
__*Fatigue Syndrome*
__*None*

Neuro:
__*Multiple Sclerosis*
__*Epilepsy*
__*Cerebral Palsy*
__*Tumor*
__*Stroke/CVA*
__*Migraine*
__*Autism* __*None*

GI:
__*Crohn's*
__*Colitis*
__*Ulcer*
__*Acid Reflex*
__*Celiac Disease*
__*None*

Hem/Lymph:
__*Anemia*
__*Large – Volume Blood Loss*
__*Ulcer*
__*High Cholesterol*
__*None*

ENT:
__*Hearing Loss*
__*Sinusitis*
__*Dry Mouth*
__*Laryngitis* __*None*

Endo:
__*Type 2 Diabetes*
__*Type 1 Diabetes*
__*Thyroid Dysfunction*
__*Hormonal Dysfunction* __*None*

Cardiovascular:
__*High Blood Pressure*
__*Congestive Heart Failure*
__*Heart Disease*
__*Vascular Disease*
__*Stroke/CVA* __*None*

Integ:
__*Eczema*
__*Rosacea*
__*Psoriasis*
__*Herpes Simplex/Cold Sores*
__*Herpes Zoster/Shingles*
__*None*

__Tuberculosis __HIV/AIDS __Hepatitis
__*None*

Psych:
__*Depression*
__*Attention Deficit*
__*Anxiety Disorder*
__*Bipolar Disorder* __*None*

Respiratory:
__*Cigarette Smoker*
__*Asthma*
__*Bronchitis*
__*Emphysema*
__*Chronic Obstruction (COPD)*
__*Sleep Apnea* __*None*

Musc/Skel:
__*Osteoarthritis*
__*Arthritis*
__*Fibromyalgia*
__*Muscular Dystrophy*
__*Ankylosing Spondylitis*
__*Osteoporosis*
__*Gout* __*None*

Allergy/Imm:
__*Drug Allergies*
__*Environmental Allergies*
__*Rheumatoid Arthritis*
__*Lupus*
__*Sjogren's Syndrome* __*None*

GU:
__*Kidney Disease* __*Prostate disease/Cancer* __*STD-Herpetic/Chlamydia*
__*Benign Prostate Hypertrophy* __*Herpes* __*Chlamydia*
__*None*

Alcohol Use: __*Y* __*N*

Tobacco Use: __*Y* __*N*

" Women only " *Are you currently:*
__*Pregnant* __*Nursing*

Have you ever been diagnosed with:
__*Cataracts*
__*Glaucoma*
__*Retinal Detachement*
__*Lazy Eye/Amblyopia*
__*Macular Degenration*
__*Dry Eyes*
__*Strabismns/Eye Turn*
__*Retinal Hole*
__*Blindness*
__*Other* _____
__*None*

** Please Initial on line Below **

_____

Family Health History: *Use indicators below to notify which family member applies*
M = Mother F = Father B = Brother S = Sister So = Son D = Daughter

Cancer _____
High Blood Pressure _____
Diabetes Type 1 _____
Diabetes Type 2 _____
Thyroid Hyper _____
Thyroid Hypo _____

Cataracts _____
Glaucoma _____
Macular Degeneration _____
__*None*

***Please list all medications you are taking*:** *(Include all vitamins and supplements)*

	Dose		Dose
1.. _____	____	*8.* _____	____
2.. _____	____	*9.* _____	____
3.. _____	____	*10.* _____	____
4.. _____	____	*11.* _____	____
5.. _____	____	*12.* _____	____
6.. _____	____	*13.* _____	____
7.. _____	____	*14.* _____	____

** Note: We will copy your list of medications for you. **