New Patient Health History Form

Name _____ Date of Birth _____ M or F
Address _____City: _____
State _____Zip _____
Phone # _____ Secondary Phone # _____
Occupation _____
Emergency Contact Name & Phone #_____
Email: _____
Preferred Language: _____

Last Eye Exam date _____ Previous Eye Doctor _____
Vision Insurance _____Primary on Vision Insurance _____
Vision Insurance # or ID _____ Health Insurance _____

Last Medical Exam _____
Major Health Issues: Check circle for all that apply
◯ Diabetes ◯ High Blood Pressure ◯ Cardiovascular ◯ Headaches
◯ Respiratory ◯ Skin ◯ Ear/Nose/Throat ◯ Musculoskeletal
◯ Elevated Cholesterol ◯ Other: _____
Medications (list)_____
_____
Allergies to medicine (list) _____
Do you smoke? Yes No

Ocular Health Issues: Check circle for all that apply
◯ Retinal Detachment ◯ Cataracts ◯ Macular Degeneration ◯ Glaucoma
◯ Dry Eye ◯ Blurred Vision ◯ Other: _____
◯ Eye Surgery: _____◯ Eye injury: _____

Family medical Hx: Check circle for all that apply
◯ Diabetes ◯ High Blood Pressure ◯ Macular Degeneration
◯ Glaucoma ◯ Retinal Detachment ◯ Cataracts
◯ Other: _____

Do you wear glasses? ◯Yes ◯No
Do you wear contact lenses? ◯Yes ◯No Type: _____
Are you interested in a contact lens fit today? ◯Yes ◯No

I. Privacy Disclosure (HIPAA)

Federal regulations require that we inform you that we are obligated to protect the privacy of our patients. No information obtained through your exam can be shared without your written permission. Medical care often requires submissions to third parties where insurance benefits are involved. Only required data will be given as necessary to file your claim. You may revoke permission to obtain, review and/or share this information at any time. As custodian of records, be assured that we will personally secure them in office. Furthermore, where benefits are legally assigned for services and materials rendered, you hereby give permission for Dr. Horie and associates to submit claims where appropriate and promise fair compensation for what insurance does not cover. You are also authorizing our office to contact you in order to arrange appointments, obtain additional information and to collect fees owed. Please sign below acknowledging that you have read and understand the office privacy policy. A copy of this form is available at your request.

II. Informed Consent for Dilated Fundus Exam

Pupil dilation is recommended every 2 years to thoroughly evaluate internal eye health. Dilation is recommended at least every year for diabetic patients and those with ocular conditions that need to be monitored. Without dilation, serious eye diseases may go unseen, which include but are not limited to, ocular diabetic complications, retinal detachment, tumors and hypertensive vessel changes. Such conditions can lead to vision loss, blindness or even death. There is no alternative procedure that can replace a dilated fundus exam. By signing below, you agree to indemnify, hold harmless, waive and release from any and all claims or legal actions that may arise as a failure to comply with the instructions and recommendations regarding dilation. I also understand that if my medical history warrants dilation, my doctor has the authority to insist on the procedure in order to continue with the examination.

Please check one: ◯ I agree to dilation today. ◯ I refuse dilation today.
◯ I will be responsible for rescheduling my dilation.

III. OPTOS Retinal Imaging

Retinal imaging is a recommended procedure to help the doctor attain a wider view of the retina and posterior eye structures. This can be done without dilation, but does not replace a dilated eye exam. Retinal images are kept on file and act as a permanent photographic record that will aid in the monitoring of hypertension, ocular diabetic changes, macular degeneration and other eye abnormalities. If you would like to have retinal imaging done please check the box below.

◯ I agree to OPTOS retinal imaging and I agree to pay the $10.00 copay for the procedure.
◯ I do not want OPTOS retinal imaging at this time.

Patient/Guardian signature: _____ Date :_____