Last Name _____**First** _____ **MI**___**Gender** ___ **DOB**_____

Address_____

City _____**State** _____ **Zip** _____

Home # _____ **Cell #**_____

Email_____

Occupation _____ **Emergency Contact Info**_____

Personal Eye Information

Reason(s) for visit ▫ Eye Exam ▫ First time contact lens fitting ▫ Update for current contact lenses ▫ Medical problem

Date of last eye exam _____ Were you dilated? Yes / No

Do you have any of the following? (circle all that apply or ▫ check here if none apply)

Blurred vision Glaucoma Cataracts Dry eyes Macular degeneration Retinal detachment Flashes Floaters

Do you have any other eye conditions or problems? Yes / No Describe

_____

Have you had any eye injuries or surgeries? Yes / No Describe

_____

Do you wear glasses? Yes / No Contact Lenses? Yes / No What type?

_____

General Medical Information

What is your general health? _____ Date of last physical exam _____ Preg Y OR N OR NA

Name of PCP_____ #_____

Do you have problems with any of these systems? (Please circle yes or no)

Cardiovascular (Heart) Yes / No **Urinary / Genital** Yes / No **Endocrine (glands)** Yes / No

High Blood Pressure Yes / No **Muscles / Bones** Yes / No **Blood / Lymph** Yes / No

Ears / Nose / Throat Yes / No **Integumentary (Skin)** Yes / No **Allergic / Immunologic** Yes / No

Respiratory (Lungs) Yes / No **Nervous System** Yes / No **Headaches** Yes / No

Gastrointestinal Yes / No **Psychiatric** Yes / No **Eyes** Yes / No

Please explain

_____

Diabetes Yes / No Type _____Date of diagnosis _____ Last BS _____Last A1C _____

Other health issues:

_____

Currents medication(s) (▫ check if none)

_____

Allergies to medication? Yes / No Which? _____

Reactions_____

Have you had any surgeries? Yes / No (What and When) _____

_____

Family History

High blood pressure Yes / No Relation _____Macular Degeneration Yes/ No Relation _____

Diabetes Yes / No Relation _____ Retinal detachment Yes / No Relation _____

Glaucoma Yes / No Relation _____ Cataracts Yes / No Relation _____

Cancer Yes/ No Relation _____ Thyroid Issues Yes/ No Relation _____

Dilation Information It is our goal to provide a complete and thorough comprehensive eye examination. To effectively accomplish our goal, we feel it is important to dilate the pupils of your eyes. This will require placing drops in your eye. As with many medications, there are some side effects of the drops used to dilate the pupil. These include sensitivity to light and blurred reading vision. In most cases, the distance vision will not be affected. The side effects usually last several hours but can, in some instances, last up to 24 hours. While we believe that dilation is an important part of the eye examination process, we understand that you may wish to defer or decline this procedure. Please indicate your preference below.

☐ I agree to be dilated today.

☐ I do not agree to be dilated and agree to hold Land O' Lakes Optical harmless as a result of my actions.

_____ Initial here

HIPPA Compliance Acknowledgement of Receipt: I acknowledge that I received a copy of Land O' Lakes Optical notice of privacy practices.

Patient or Guardian Signature: _____Date: ___/___/_____

If you are using insurance, please complete the following section:

Name of insurance _____Primary Insured's Name_____

Primary Insured DOB _____ Member Id#_____

(Please note that verification of Insurance does not guarantee payment from the insurance company)

Lifetime Patient Signature (Your signature below is required to bill your insurance company) I request that payment of authorized Medicare, or other insurance benefits either to me or on my behalf be made to Land O' Lakes Optical for any services furnished to me by the doctor. I authorize any holder of medical information about me to be released to my insurance company or Centers for Medicare Services and its agent any information needed to determine these benefits or the benefits payable for related services. Verification of eligibility at the time of service(s) is not a guarantee of payment from your insurance company. If your insurance company denies or fails to pay on your behalf, you acknowledge and agree to be directly responsible for all payments, in full, on services and or products to Land O' Lakes Optical.

Patient or Guardian Signature: _____ Date: ___/___/_____

Please Check Below On How You Plan on Paying for Today's Visit
__Visa __Mastercard __Discover __Check __Cash __ CareCredit