Vibrant Eyecare, PLLC

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*** OFFICE USE ONLY ***	
Appointment time:_____Arrival:_____ Walk-in:_____	Insurance name_____ Payment method: Cash, Credit, CareCredit Copayment: $_____

PATIENT INFORMATION

Circle one: New patient or Established patient

Name: First_____ Last _____ Social Security Number_____

Birthdate_____ Gender (*circle*): M or F

Address_____ City_____ State_____ Zip code_____

Home Telephone:(____)_____ Cellphone:(_____)_____

Email_____ Occupation / Job_____

Relationship to insured (*circle*): Self / Spouse / Child

Last eye exam_____ How did you hear about us?_____

Primary Insurance Holder

Patient and primary insurance holder are the same: ☐ Employer: _____

Name: First_____ Last _____ Social Security Number_____

Birthdate_____ Gender (*circle*): M or F

Address_____ City_____ State_____ Zip code_____

Home Telephone:(____)_____ Cellphone:(_____)_____

Name of insurance_____ Member ID #_____

MEDICAL HISTORY

PHYSICAL
☐ Developmental ☐ Cancer ☐ Fatigue

EAR, NOSE, THROAT
☐ Hearing loss ☐ Sinusitis ☐ Dry mouth ☐ Laryngitis

NEUROLOGICAL
☐ Multiple Sclerosis ☐ Epilepsy ☐ Cerebral Palsy ☐ Tumor
☐ Migraine

PSYCHIATRIC
☐ Depression ☐ Attention Deficit ☐ Anxiety ☐ Bipolar

CARDIOVASCULAR
☐ **High blood pressure** ☐ Stroke ☐ Heart disease
☐ Vascular disease ☐ Congestive heart failure

RESPIRATORY
☐ Smoker ☐ Asthma ☐ Bronchitis ☐ Emphysema
☐ Chronic obstruction ☐ Sleep apnea

GASTROINTESTINAL
☐ Crohn's ☐ Colitis ☐ Ulcer ☐ Acid reflux ☐ Celiac disease

GENITOURINARY
☐ Kidney disease ☐ Prostate cancer ☐ STD
☐ Benign prostate hypertrophy ☐ Pregnant ☐ Nursing ☐ Herpes
☐ Chlamydia

MUSCULOSKELETAL
☐ Osteoarthritis ☐ Arthritis ☐ Fibromyalgia ☐ Muscular dystrophy
☐ Ankylosing spondylitis ☐ Osteoporosis ☐ Gout

INTEGUMENTARY / SKIN
☐ Eczema ☐ Rosacea ☐ Psoriasis ☐ Herpes simplex
☐ Herpes zoster / Shingles

ENDOCRINE
☐ **Type 2 diabetes** ☐ Type 1 diabetes ☐ Thyroid dysfunction
☐ Hormonal dysfunction

HEMATOLOGIC / LYMPHATIC
☐ Anemia ☐ Large volume blood loss ☐ Ulcer ☐ **Cholesterol**

ALLERGIC / IMMUNE
☐ Drug allergies ☐ Environmental allergies ☐ Rheumatoid arthritis
☐ Lupus ☐ Sjogren's syndrome

SOCIAL HISTORY: ☐ Smoke ☐ Drink

WOMEN: ☐ Pregnant, How many months?_____ ☐ Lactating

OCULAR HISTORY

Have you ever been diagnosed with any of the following?

Cataracts ..... YES / NO
Macular degeneration ..... YES / NO
Glaucoma ..... YES / NO
Diabetic retinopathy ..... YES / NO
Dry eyes ..... YES / NO
Floaters ..... YES / NO
Flashes of light ..... YES / NO
Iritis / Uveitis ..... YES / NO
Retinal tear/ retinal detachment ..... YES / NO

Are you having any of the following eye concerns?

Red eyes ..... YES / NO
Burning ..... YES / NO
Itching ..... YES / NO
Tearing ..... YES / NO
Discharge ..... YES / NO
Blurred vision ..... YES / NO
Eyestrain ..... YES / NO
Eye pain ..... YES / NO
Severe sensitivity to light ..... YES / NO
Headache ..... YES / NO
Poor night vision ..... YES / NO
Bothersome night glare ..... YES / NO
Double vision ..... YES / NO
Total vision loss ..... YES / NO

Eye injuries ..... YES / NO
Eye surgeries ..... YES / NO
Eye turn or lazy eye ..... YES / NO

MEDICATIONS

_____

_____

_____(None)

ALLERGIES (medication and food)

(None)

FAMILY MEDICAL AND OCULAR HISTORY

Immediate family members

Cancer ..... YES (Who?_____) / NO
Diabetes Type 1 ..... YES (Who?_____) / NO
Diabetes Type 2 ..... YES (Who?_____) / NO
High blood pressure ..... YES (Who?_____) / NO
Thyroid dysfunction ..... YES (Who?_____) / NO
Macular degeneration ..... YES (Who?_____) / NO
Glaucoma ..... YES (Who?_____) / NO

RETINAL PHOTOGRAPHY

Retinal photography uses a special high-resolution digital camera to take detailed photos of your retina, the inside back structures of your eyes. It is used to help detect and manage common **eyes diseases such as diabetes, glaucoma, cataracts and macular degeneration**. Many eye and systemic conditions, if detected at an early stage, can be treated successfully without loss of vision**.**
Your retinal images will be stored electronically. This gives the doctor a visual record of the current state of your retina that can be used to manage the progression of said conditions. **We recommend that all of our patients receive this test**. It is especially important for people with **personal** and **family history of high prescriptions, high blood pressure, diabetes, retinal diseases, flashing lights, floaters or headaches**. We strongly believe in the early detection and treatment of all ocular conditions. Retinal photography is a quicker and safer method compared to dilation; there are **no eye drops or negative side effects**. Dilation will lengthen your visit by at least 45 minutes and you will have negative side effects of light sensitivity and blurry vision for 4 (four) to 6 (six) hours.

I choose to have retinal photography: ☐ **YES** ☐ NO

I choose to have pupil dilation: ☐ YES ☐ NO
(I understand that by choosing to be dilated I will suffer from blurry vision and light sensitivity and driving is not recommended in that condition)

FINANCIAL RESPONSIBILITY

By signing below, I acknowledge that all information entered is correct and accurate on all patient information sheets. I accept complete financial responsibility for all expenses incurred on today's visit and understand that payment is due before services are rendered and are non-refundable. If insurance fails to pay, the patient / parent / guardian will be held responsible for any materials or services not covered by insurance. Failure to remit payment will result in account being sent to collections. I authorize payments of my visual and medical benefits to Lorenzo Nichols, O.D. / Vibrant Eyecare, PLLC. I authorize the release of medical and necessary information to process all claims and payments to the party who accepts assignment.

I understand that this office will automatically schedule annual eye exams. Multiple notifications of said exams will be sent via text messages, telephone (cellular phone / landline), and / or email as the scheduled annual eye exam nears.

Initials:_____

HIPAA PRIVACY
ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

By signing below, I acknowledge that I received a copy of Vibrant Eyecare, PLLC's Health Insurance and Portability and Accountability Act (HIPAA) form via their website / patient portal / in person.

Signature of Patient / Responsible Party_____Date_____