

WELCOME TO OUR OFFICE!

Please fill in the blanks and answer the questions below.

How did you learn about our office? _____

Name: _____ Home Phone: _____ Work Phone: _____

Address: _____ Cell Phone: _____ Pager: _____

City: _____ State: _____ Zip: _____

Birth Date: _____ SS #: _____ Email: _____

Employer: _____ Occupation: _____

Ins. Co: _____ Policy No: _____ Group No: _____

Reason for your visit today?

Are you interested in: Contacts? Y N Laser Vision Correction? Y N Clear vision without daytime glasses, contacts or surgery? Y N

Dilation is the best way to examine the inside of your eyes.

Unless you indicate below with your signature, your eyes will be dilated (unless it is medically unwise to do so). While objects will appear glary, you will be able to see afterwards. Reading might be difficult without correction for about 2-3 hours. Use of sunglasses (provided in our office) is advised if it is sunny outdoors.

By signing below, I acknowledge that I have been advised that dilation is an essential part of a vision and eye health examination. I understand that if not dilated, my doctor might miss seeing inside my eyes signs of serious health problems such as, but not limited to, diabetes, high blood pressure, glaucoma, cataracts, and possibly even cancer. I hold Dr. Friedberg and his agents harmless for any circumstance which might later occur as a result of a condition not detected.

SIGN ONLY IF DECLINING DILATION >>>> Signature: _____ Date _____

When was your last eye exam? _____

Who was the Dr.? _____

Please answer the following:

Blurred far away vision Y N
Blurred close up vision Y N
Headaches? Y N
Fatigue or eyestrain when using a computer? Y N
Do you lose your place when you read? Y N
Have you ever had eye surgery? Y N
Do your eyes get dry a lot? Y N
Do your eyes get watery a lot? Y N
Do your eyes itch? Y N
Have you ever seen flashes of lights? Y N
Do you have double (two of things)? Y N

What medications do you take?

What are you allergic to?

When was your last physical exam? _____

Who was the Dr.? _____

Do you or anyone in your family have:

High blood pressure? No Self Family
Heart Disease? No Self Family
High Cholesterol? No Self Family
Diabetes? No Self Family
Thyroid Disease? No Self Family
Cancer? No Self Family
Glaucoma? No Self Family
Retina Problems? No Self Family

Other? _____

Do you smoke? Y N
Do you use recreational drugs? Y N
Alcohol consumption per day? _____
Females, are you pregnant? Y N

I am the patient, the parent, or the guardian of the minor child whose name appears above. I hereby consent to have Horizon Eye Care and Optical to perform such eye care and treatment as it deems necessary or appropriate for myself, or my child. I further agree to pay for goods and services purchased from Horizon Eye Care and Optical. I understand I am financially responsible for all charges incurred during the course of this visit whether covered by my insurance or not. I understand that there may be tests performed which my insurance company does not regard as a part of what they consider to be a standard vision examination. I authorize payment to the physician directly and also authorize the physician and/or staff to release any information needed in the processing of any claims. I understand there is a \$20 return check fee and that finance charges of 1.5% per month will accrue for balances 30 days or more past due.

Patient or Guardian

Date

Printed Name of Guardian if Patient is a Minor