Patient Information

Personal

Mr.___ Mrs. ___ Miss___ Ms.___ Dr.___

Last Name _____ First_____ MI_____ Sex: M___ F___ D.O.B._____

Address _____ City_____ State_____ Zip_____

Occupation_____ Employer _____

Email Address _____ @ _____

Phone Numbers

Home Phone (____) _____ Work Phone (____) _____ Cell Phone (____) _____

Insurance Information

Insurance Co._____ Insurance Plan/ID# _____

Primary Cardholder_____ Primary's D.O.B_____

Primary's S.S.# ____-___-_____ Patient's S.S.# ____-___-_____

Health Information

Reason for this visit: ___ Routine Exam for Eyeglasses ___ Routine Exam for Eyeglasses and Contacts

___ Eye Infection ___ Eye Injury

___ Other _____

Last Eye Exam: _____ Dr.'s Name: _____

Have you had any surgery or injury to or around your eyes? _____ If yes, explain:_____

_____

_____

Last Physical Exam: _____ Dr.'s Name: _____

Please list any and all medications you are currently taking, including eyedrops, hormones, and birth control (if you do not know the name of the medication, please list the reason for taking it):

_____

_____

Are you pregnant: No___ Yes ___ # of months _____

Health History (please check all that apply)

	You	Relative		You	Relative
Glaucoma			Diabetes		
Cataracts			High Blood Pressure		
Lazy Eye			Low Blood Pressure		
Blindness			Heart/Vascular Disorder		
Allergies			Thyroid Disorder		
Color Blindness			Cancer/Tumors		
G.I. Disorder			Retinal Disorders		
Kidney/Liver Disorder			Asthma/Bronchitis		
Arthritis			HIV		
Fainting/Dizziness			Other		

(Please fill out back of form)

Our goal is to set the standard in professional, quality eye care. We are committed to prevention of eye diseases as well as early detection. Using the most advanced equipment and techniques we can often identify changes at early stages before they become problems. For these reasons **we strongly recommend** that our patients receive the following tests as part of their visual analysis.

Visual Field Screening Analysis

Virtually All of the Major Causes of Blindness in the United States Can Be Detected by Changes in the Visual Field. A highly sophisticated computerized instrument now enables us to provide a more thorough visual field screening analysis. This instrument checks for areas of loss of sight both in the central (straight ahead) and peripheral (side view) areas. Visual field testing assists us in early detection of glaucoma, retinal problems, some neurological diseases (such as brain tumors and optic nerve disease), and enables us to better diagnose the causes of headaches. Unfortunately, most visual field defects are not noticed until very late stages. Early detection significantly increases the chances of treating the disorder, or at least minimizing its effects. ***Studies have shown this test to be the most accurate screening test for glaucoma.*** **The fee for this additional test is $15.00**

Do you want to have the visual field screening? YES_____ NO_____

Dilation: It is our goal to provide you 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 eyes, which will open the pupil (black spot) and allow a better view of the inside of 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 (in most cases the distance vision will be unaffected). The side effects last several hours and in some cases may last as long as 24 hours.

While we believe dilation is an important part of the eye examination process, we understand that you may not want to, defer or omit to this procedure. *Please indicate your preference below.*

____ I wish to be dilated today.

____ I do not wish to be dilated at this time but will return at a later date (***there is no additional charge when you return for routine dilation***).

____ I do not wish to be dilated and agree to hold Dr. Goldberg O.D., P.A. Harmless as a result of my actions.

Payment for the doctor is required at the time of service

We accept the following forms of payment: Cash, Check, American Express, Mastercard, and Visa. If you are paying by check we require a valid driver's license and your check will be processed by Telechek Check Protection Service. Returned checks will be assessed a $25.00 service charge.

Insurance Billing Patient Signature:(your signature is required below which will allow us to bill your insurance company)

I request that payment of authorized Medicare, Superior Vision, Eyemed, or other insurance benefits either to me or my behalf be made to Dr. Goldberg O.D., P.A. for any services furnished me by that doctor. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agent any information needed to determine these benefits or the benefits payable for related services. I also understand that if my insurance company does not provide payment to Dr. Goldberg O.D., P.A., I will be billed for and agree to pay for said service.

By signing below, I acknowledge that I have read and understand all the information on this page.

PATIENT/GUARDIAN SIGNATURE:_____ DATE:_____