1391 Smizer Mill Road, Suite 102
Fenton, MO 63026-7306
(636) 305-9600 Phone
(636) 305-9601 Fax
contactus@fentonfamilyeyecare.com

Welcome to our office! In order to provide the best service to you, we need the following information. All information will remain confidential. Thank you.

Patient Full Name ____ Today's Date ____/____/______

Date of Birth _____/_____/________ Social Security # _______ - _____ - _____________

Address ________________________________ City ___________________ State _______ Zip ________________
Phone
(Home) _________________________ (Cell) __________________________ (Work) ________________________

Place of Employment: _____________________________________ Occupation: __________________________

E-Mail Address ____ If Student, School Attending: _______________________
Will only be used for secondary office communication to you

Marital Status: ☐ Single ☐Married ☐Widowed ☐Divorced ☐Separated

How did you hear about our office? ____

Do you have vision insurance? ☐Yes ☐No

Do you have medical insurance? ☐Yes ☐No

Vision Insurance Provider: __________________________
Present card to receptionist

Medical Insurance Provider: ______________________
Present card to receptionist

Vision Insurance ID No. ________________
Group No. ________________

Medical Insurance ID No. ___________________
Group No. ___________________

Person responsible for account (if different from Patient): _____________________________ DOB: ___/___/_______

Relationship to Patient: ____

Mailing Address (if different) ____

____

Phone ____

***********PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED***********
We accept Visa, Mastercard, Discover, Care Credit,
Debit Cards, Cash & Checks ($25 fee for all returned checks)
A fifty percent (50%) deposit on all contact lenses and glasses is required before an order can be placed. The balance must be paid in full before they are **dispensed**.

Signature: ______________________________________ Date: ___________________________

MEDICAL HISTORY QUESTIONNAIRE Today's Date ____/____/________

Name of Medical Doctor __________________________ Last Medical Exam ____/____/________ Reason: ____________________

Name of Previous Eye Doctor ____ Last Eye Exam ____/____/________

Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)? ☐ Yes ☐ No

Do you wear glasses? ☐ Yes ☐ No If yes, how old is your present pair of lenses? ___________________________________

Do you notice reflection on the lenses of your glasses? ☐ Yes ☐ No
Is it hard to keep the lenses of your glasses clean? ☐ Yes ☐ No
Do you have problems with glare while driving at night? ☐ Yes ☐ No
Do you wear prescription sunglasses? ☐ Yes ☐ No

Are you interested in contact lenses today? ☐ Yes ☐ No If yes, a contact lens exam requires additional testing, and therefore, has an additional service fee. You must read and sign a Contact Lens Agreement.

Do you wear contact lenses? ☐ Yes ☐ No If yes, what type? ☐ RGP ☐ Soft
Do you know what brand of lenses? ____________________________________
List prescription if known RT ________________ LT ________________
Do you sleep in them? ☐ Yes ☐ No
Are they comfortable? ☐ Yes ☐ No
How frequently do you replace them? ☐ Daily ☐ Monthly ☐ 2-weeks
How many hours do you typically wear them? _______ How Long Today? _________
What type of solution do you use? ________________________
(i.e. OptiFree, Complete, etc.)

OCULAR COMPLAINT(S)

Are you currently experiencing any of the following problems with your eyes? **Check the box if "yes."**

☐ Blurred vision
☐ Loss of Vision
☐ Loss of Side Vision
☐ Distorted Vision
☐ Double Vision
☐ Tired Eyes
☐ Flashes/Floaters in Vision
☐ Halos
☐ Glare/Light Sensitivity
☐ Dryness
☐ Sandy or Gritty Feeling
☐ Foreign Body Sensation
☐ Burning
☐ Itching
☐ Redness
☐ Excess Tearing/Watering
☐ Eye Pain or Soreness
☐ Mucous Discharge
☐ Chronic Infection of Eye/Eyelid
☐ Styes or Chalazion
☐ Other _____________________________

For checks above, please indicate:

Date of Onset ____/____/________

Location ☐ right eye ☐ left eye ☐ both eyes ☐ Other ____

How long have you experienced ☐ 1 Day ☐ 1 Week ☐ 1 Month ☐ Other _____________________________

When do you notice this problem ☐ Morning ☐ Afternoon ☐ Evening ☐ Seasonal ☐ Other ______________

Describe the problem ☐ Progressive ☐ Painful ☐ Improving ☐ Worsening ☐ Other _____________________

When do you most experience your problem ☐ Resting ☐ Reading ☐ Driving ☐ Other ______________

Describe the severity of your problem ☐ Mild ☐ Moderate ☐ Severe

Describe factors that help decrease the problem ☐ Low Light ☐ Medication ☐ Sleep ☐ Other ______________

What symptoms do you experience ☐ Loss of Vision ☐ Irritation ☐ Burning ☐ Other ______________

On a scale of 1thru 10, what is your pain today? ______ On a scale of 1 thru 10, what was your worst pain? _____ Best? _____

REVIEW OF SYSTEMS Please check the box beside any problem you currently have, or have ever had, in the following areas:

CONSTITUTIONAL
□ Fever □ Weight Loss/Gain
□ Weakness □ Other ________________
□ All Normal

CARDIOVASCULAR/CARDIA
□ Hypertension □ Arrhythmia
□ Angina □ Other ____________________
□ All Normal

EAR, NOSE, MOUTH, THROAT
□ Hearing Aids □ Dry Mouth
□ Cough □ Other ________________
□ All Normal

RESPIRATORY
□ Congestion □ Wheezing
□ Sleep Apnea □ Shortness of Breath
□ All Normal □ Other ____________________

GASTROINTESTINAL
□ Hernia □ Upset Stomach
□ Diarrhea □ Constipation
□ All Normal □ Other _______________

GENITOURINARY
□ Kidney Stones □ Urination Problems
□ Prostrate Prob □ Ovarian Cysts
□ All Normal □ Other ____________________

MUSCULOSKELETAL
□ Arthritis □ Back Pain
□ Tendinitis □ Fybromyalgia
□ All Normal □ Other ________________

INTEGUMENTARY
□ Eczema □ Skin Cancer
□ Itching □ Dryness
□ All Normal Other ______________________

NEUROLOGICAL
□ Seizures □ Migraines
□ Vertigo □ Epilepsy
□ All Normal □ Other ________________

PSYCHIATRIC
□ Depression □ ADHD
□ Suicidal □ Agitated
□ All Normal □ Other ____________________

ENDOCRINE
□ Hypothyroid □ Diabetes Type ______
□ Pancreatitis □ Goiter
□ All Normal □ Other ________________

HEMATOLOGIC/LYMPHATIC
□ Anemia □ Cholesterolemia
□ Leukemia □ Hemophilia
□ All Normal □ Other

ALLERGIC/IMMUNOLOGIC
□ HIV/AIDS □ Transplant
□ Lupus □ Allergies Type: ________
□ All Normal □ Other ________________

OTHER
□ Dementia □ Anorexia
□ Insomnia □ Alcohol/Substance Abuse
□ All Normal □ Other ____________________

If you check any of the above boxes or have a condition not listed, please explain further: ____________________________________

____

Are you pregnant? □ Yes □ NoIf yes, how far along are you? ____________ months

Height _________ inches / Weight __________ lbs

If Diabetic, for how long? ___________________ Blood Sugar ______ mg/dl □ SMBS HbA1c ____%

Do you work on a computer? □ Yes □ No If yes, how many hours per day? _________

List all major **surgeries** and/or **hospitalizations** you have had: (attach additional sheet if necessary)

____
Date Procedure (if eye-related indicate □ Right □ Left) Surgeon

____
Date Procedure (if eye-related indicate □ Right □ Left) Surgeon

Have you ever had a blood transfusion? □ Yes □ No

PAST/PRESENT OCULAR HISTORY

Have you been diagnosed with any of the following ocular problems? **Check the box if "yes."**

☐ Glaucoma
☐ Eye Injury
☐ Blindness
☐ Diabetes
☐ Other ___________________________

☐ Cataracts
☐ Retinal Disease
☐ Strabismus (Crossed Eyes)
☐ Dry Eye

☐ Macular Degeneration
☐ Eye Disease (Type: _________________)
☐ Amblyopia (Loss of vision in one eye)
☐ Glasses/Contacts to correct vision

FAMILY HISTORY Please note any family history (mother/father, maternal/paternal grandparents (MGM, MGF, PGM, PGF), siblings, children; living or deceased) for the following conditions:

	RELATION TO YOU		RELATION TO YOU
☐ Glaucoma	______________	☐ Cataracts	______________
☐ Macular Degeneration	______________	☐ Eye Injury	______________
☐ Retinal Disease	______________	☐ Eye Disease	______________
☐ Blindness	______________	☐ Strabismus (Crossed Eyes)	______________
☐ Amblyopia	______________	☐ Diabetes	______________
☐ Cancer	______________	☐ Heart Disease	______________
☐ Other	______________	☐ Other	______________

SOCIAL HISTORY

*This information is kept strictly confidential. However, **you may discuss this portion directly with your doctor if you prefer.***
Please check the following box if you wish to discuss your Social History directly with your doctor ☐

Do you currenty use or have you ever used tobacco products? ☐ No ☐ Yes If yes, type/amount/when/how long:
____

If no, have you ever used tobacco products? ☐ No ☐ Yes If yes, how long ago? ________________________________

Do you use illegal drugs? ☐ No ☐ Yes If yes, type/amount/how long: ________________________________

Do you drink alcohol? ☐ No ☐ Yes If yes, type/amount/how long: ________________________________

Indicate by checking the box if you have been infected with or exposed to: ☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis

MEDICATIONS

List any **medications** you are currently taking (include oral contraceptives, aspirin, over the counter medications and home remedies, along with dosage in mg, how long you have been taking and prescribing doctor — attach additional sheet if necessary):

MEDICATION	DOSAGE	START DATE	PRESCRIBING DOCTOR

*If you need more room, please list additional medications on back of page.

Do you have **allergies** to any medications? ☐ Yes ☐ No If yes, please explain: ________________________________

____

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Fenton Family Eyecare's Notice of Privacy Practices.

Patient name ____

Patient E-mail ____

*Your E-mail address will only be used by this office to update you or send you notices. Your E-Mail will not be shared with any other entity.

Signature ________________________________ Date _______________

If you are signing as a personal representative or guardian of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient ______________________ Print Name _______________________________

Source of Authority ____

ABOUT YOUR INSURANCE

There are two types of health insurance that will help pay for your eye care services and products. You may have both and our practice accepts both:

1. Vision care plans (such as VSP and EyeMed);
2. Medical Insurance (such as Blue Cross/Blue Shield and Medicare).

- Vision care plans only cover routine vision exams along with eyeglasses and contact lenses. Vision plans only cover a basic screening for eye disease. They do not cover diagnosis, management or treatment of eye diseases.

- Medical insurance must be used if you have any eye health problem or systemic health problem that has ocular complications. Your doctor will determine if these conditions apply to you, but some are determined by your case history.

- If you have both types of insurance plans it may be necessary for us to bill some services to one plan and other services to the other plan. We will use coordination of benefits to do this properly and to minimize your out-of-pocket expense.

- We will bill your insurance plan for services if we are a participating provider for that plan. We will try to obtain advanced authorization of your insurance benefits so we can tell you what is covered. If some fees are not paid by your plan, we will bill you for any unpaid deductibles, co-pays or non-covered services as allowed by the insurance contract.

I have read and agree with these practices.

____ Date: ________________________

Patient Signature (Parent if Child)

CONSENT FOR RETINAL PHOTOS

As part of your eye exam, Dr. Vricella recommends a special diagnostic procedure called retinal photography. This procedure consists of taking a picture of the back of your eye for your permanent record. This is not an ultrasound or an X-ray, and nothing touches your eye.

In many instances, your medical insurance may cover the cost of these photos, especially if you have a condition such as high blood pressure, diabetes or glaucoma, to name a few. The doctor will be able to answer if you have a condition that makes these photos medically necessary, and therefore, covered by medical, not vision, insurance. Please keep in mind there can be out of pocket expenses to you if deductibles have not been met or if co-pays apply.

In other cases, your insurance may not cover a photo, but it is good documentation for our records. In this case, a screening photo may be taken at your cost. The cost for screening photos is $35.00. While taking this photo does not replace the need to have your eyes dilated, **it is strongly recommended that you have photos taken if you plan on declining having your eyes dilated at today's visit**. This is to ensure that the doctor gets a reasonable view of the eye and your retinal health. Keep in mind that if subtle pathology (disease) is identified on these photos, we may then bill your insurance for the cost.

OPTIONS:

□ I elect to have screening photos at a cost of $35.00.

□ I decline screening photos.

□ I wish to discuss the benefits with the technician before making my decision.

____
Signature

____
Printed Name

____
Date