

**PATIENT INFORMATION**

Today's Date: \_\_\_\_\_ Please Circle: Mr./ Mrs./ Ms./ Miss./ Dr./Single/ Married /Other

NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_ SEX: \_\_\_\_\_

SOCIAL SECURITY#: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_

STATE:: \_\_\_\_\_ ZIP: \_\_\_\_\_ EMAIL:\* \_\_\_\_\_

*BY PROVIDING EMAIL ADDRESS, YOU ARE AUTHORIZING TO RECEIVE CORRESPONDENCE FROM OUR OFFICE.*

HOME PHONE: \_\_\_\_\_ WORK/CELL: \_\_\_\_\_

HOW DID YOU HEAR ABOUT US: \_\_\_\_\_

REASON FOR TODAY'S VISIT: \_\_\_\_\_

\*\*\*\*\*

**INSURANCE INFORMATION**

INSURANCE COMPANY NAME: \_\_\_\_\_

POLICY HOLDER'S NAME: \_\_\_\_\_ POLICY HOLDER'S SS#: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ POLICY/ID #: \_\_\_\_\_

RELATIONSHIP TO PATIENT: SELF/ SPOUSE/ CHILD/ FULL TIME STUDENT/ DEPENDENT/ DOMESTIC PARTNER

\*\*\*\*\*

1. Occupation: \_\_\_\_\_

2. Do you wear eye glasses? \_\_\_\_\_ If no, have you every worn eye glasses? \_\_\_\_\_ If Yes, are they for:  
Distance \_\_\_\_\_, near \_\_\_\_\_, or both \_\_\_\_\_. Do you see clearly through them? \_\_\_\_\_

3. Do you, or have you every worn contact lenses? \_\_\_\_\_ If yes, type: \_\_\_\_\_ Are they for:  
Distance \_\_\_\_\_, near \_\_\_\_\_, or both \_\_\_\_\_. Do you see clearly through them? \_\_\_\_\_

4. If you have had any contact lens problems, please list: \_\_\_\_\_

5. When was your last eye exam? \_\_\_\_\_

6. Were your current glasses and/or contact lenses prescribed at that time? \_\_\_\_\_

7. Are you interested in:  
Laser Vision Correction: \_\_\_\_\_ Ortho-K (Non-surgical Vision Correction): \_\_\_\_\_  
Prescription Sunglasses: \_\_\_\_\_ Computer/Work Glasses: \_\_\_\_\_  
Contact Lenses: Daily \_\_\_\_\_ Disposable \_\_\_\_\_ Rigid \_\_\_\_\_ Colored \_\_\_\_\_ Bifocal \_\_\_\_\_

I hereby assign the policy rights and benefits to Dr. Douglas M. Lee, and authorize direct payment for professional services and/or optical equipment rendered. I further authorize this office to release any information concerning my examination or treatment to my insurance company. I agree to be personally responsible for any unpaid balances or copayment or deductibles to the doctor, and if I receive any payments from my insurance company in error, I will sign them directly over to this office.

Patient Signature (Parent if minor): \_\_\_\_\_ Date: \_\_\_\_\_

## DILATION CONSENT

Dear Patient:

Our goal is to provide you with the most thorough eye exam available. In order for us to accomplish this goal, we need to dilate your eyes. Dilation allows us to thoroughly view the retina and other internal structures.

Dilation consists of placing drops in your eyes which will enlarge your pupils. Dilation usually occurs within 15-20 minutes after the drops are installed. Due to the widening of the pupil, dilation will blur your vision at near for 3-4 hours. Dilation will also create light sensitivity. You should use caution, when driving or engaging in other hazardous activities while your pupils are dilated. If you do not have a pair of sunglasses, we can provide you with a pair of disposable sun shades. Please ask for a pair at the front desk before you leave.

**We strongly recommend dilation especially if you or a family member has a history of diabetes, retinal disease, flashes or floaters, glaucoma, cataracts, macular degeneration, a moderate or high degree of nearsightedness or if you have not had your eyes dilated within the past two years.** In some cases dilation may be the only effective way of detecting diseases of the retina and other internal structures of the eye. The fee for the dilation is covered by Medicare and most vision insurance programs.

If you do not have insurance or if your insurance does not cover the dilation exam, the fee is \$\_\_20.00\_\_\_\_\_.

Please check the appropriate box below and sign:

I would like a comprehensive exam with dilation.

I understand the importance of dilation and that it would be in my best interest for evaluating the health of my eyes; however, at this time I decline to be dilated.

Patient's Name: \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Sincerely,

Dr. Douglas M. Lee & Staff

**Family Vision Center  
Dr. Douglas M. Lee  
1734 Lincoln Highway  
Edison, NJ 08817**

I, \_\_\_\_\_ hereby acknowledge receipt **of Family Vision Center's Notice of Privacy Practice** on behalf of myself and my dependent(s).

Dependent's Name:

Date of Birth:

---

---

---

---

---

---

---

---

---

---

---

---

---

---

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## MEDICAL HISTORY

Name: \_\_\_\_\_

Date: \_\_\_\_\_

**Self**

**Family**

High blood pressure

\_\_\_\_\_

\_\_\_\_\_

Arthritis

\_\_\_\_\_

\_\_\_\_\_

Eye infections

\_\_\_\_\_

\_\_\_\_\_

Headaches

\_\_\_\_\_

\_\_\_\_\_

Lazy Eye

\_\_\_\_\_

\_\_\_\_\_

Double Vision

\_\_\_\_\_

\_\_\_\_\_

Cataracts

\_\_\_\_\_

\_\_\_\_\_

Eye surgery

\_\_\_\_\_

\_\_\_\_\_

Recent weight loss/gain

\_\_\_\_\_

\_\_\_\_\_

Eye pain

\_\_\_\_\_

\_\_\_\_\_

Allergies (food and /or medication)

\_\_\_\_\_

\_\_\_\_\_

Heart Condition

\_\_\_\_\_

\_\_\_\_\_

Diabetes

\_\_\_\_\_

\_\_\_\_\_

Glaucoma

\_\_\_\_\_

\_\_\_\_\_

Amblyopia

\_\_\_\_\_

\_\_\_\_\_

Eye turn

\_\_\_\_\_

\_\_\_\_\_

Smoking

\_\_\_\_\_

\_\_\_\_\_

Alcohol use

\_\_\_\_\_

\_\_\_\_\_

Colored rings around lights

\_\_\_\_\_

\_\_\_\_\_

Unusual sensitivity to lights

\_\_\_\_\_

\_\_\_\_\_

Flashes or floaters

\_\_\_\_\_

\_\_\_\_\_

Other

\_\_\_\_\_

\_\_\_\_\_

Please explain: \_\_\_\_\_

- Are you currently under the care of a physician for any health problems?
- Have you ever suffered a serious illness? \_\_\_\_\_ If yes, explain: \_\_\_\_\_
- Are you currently taking any medication? \_\_\_\_\_ If yes, please list: \_\_\_\_\_

\_\_\_\_\_