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 explan:_____

- 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: _____

_____