4SIGHT iCARE PATIENT FORMS

PATIENT'S NAME: ____

-if a minor,
GUARDIAN'S NAME & RELATION: ______________________________

To acknowledge that the "Notice of Privacy Practices" is available to you, **initial here:** ________

Receiving care from another eye doctor?___No___Yes (Name): ___________________________

PRIMARY CARE PHYSICIAN & PHARMACY

Doctor Name:___________________________ Practice Name:__________________________
Office Phone: ___________________________ Office Fax: _____________________________
Pharmacy (name & location): ____

REASON(S) FOR VISIT (CHECK ALL THAT APPLY):

___Annual Eye Exam ___Eyeglasses ___Contact Lenses ___Medical Office Visit

THE iHEALTH WELLNESS EXAM:

At 4Sight iCare our mission is to help you SEE YOUR BEST. This means we endeavor to educate ways to protect your eyes & preserve healthy vision throughout your lifetime, provide a wide range of vision correction options from vision shaping retainers to the most modern multifocal lenses, invest in the most advanced equipment to evaluate and manage your eyes, and optimize your visual performance through ocular nutrition and/or vision training when appropriate. We bundle several screenings together to identify ways we can help beyond 20/20 that some but not all insurances cover completely at a $0 copay. The tests performed are determined by a number of factors: 1) only age appropriate tests approved by your eye doctor, 2) only CPT coded tests not billable to medical insurance on the same visit, 3) any insurance coverages/discounts applied, and 4) all advanced instrumentation deemed necessary by your eye doctor to provide you comprehensive eye care. Prior to insurance the cost is up to $97.

I am the responsible party for this patient account: __Yes__No (Name): ____________________

I authorize and request my insurance company pay directly to the doctor insurance benefits otherwise payable to me for any covered services that can be submitted to my carrier.

I acknowledge that whenever possible, medical insurance will be billed for medical office visits along with any associated procedures and that wellness visits will be billed to vision plans.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.

SIGNATURE:____ **DATE:** ___/___/_____

Give your i-Care visit some 4-thought

CHECK ALL DISTANCES YOU WEAR GLASSES/CONTACTS:

Far   Reading   Computer   None

How is your vision **with** your preferred vision correction at each distance?

Far:	Acceptable	May need improvement	Blurry
Near/Read:	Acceptable	May need improvement	Blurry
Computer:	Acceptable	May need improvement	Blurry

CHECK ALL THAT APPLY OVER THE PAST 3 MONTHS: score: (____)

In the last 3 months, how often have you experienced:	Constantly (3)	Daily (2)	Weekly (1)	Never (0)
Eye discomfort or itch?				
Burning sensation?				
Gritty/sandy sensation?				
Eye redness?				
Watery eyes?				
Fluctuating vision?				

CHECK ALL THAT YOU'RE EXPERIENCING NOW:

	Eye pain		Eyestrain		Headache
	Double Vision		Burning		Discharge
	Poor Night Vision		Bothersome Glare		Light Sensitivity
	Total Vision Loss		Other: __________		**None of these**

Indications for dilation include but are not limited to the following: pertinent family/personal medical history, recent eye/head injury, or abnormal tests results. Not having a dilated eye exam when indicated and/or failing to attend a medical eye care visit may be detrimental to your health and vision.

Dilation is an important part of an eye exam. It opens the pupil to better evaluate eye health, but it has temporary side effects: Light sensitivity & blurred near vision that may last up to six hours. Please, only drive once comfortable with your vision.

Pupil dilation is not recommended for patients who are pregnant, nursing, or allergic to the dilating agents (proparacaine, phenylephrine/hydroxy-amphetamine hydrobromide, & tropicamide).

Initial which best represents your wishes:

_____ **NO** dilation eye drops today. If medically indicated, I shall schedule it to be done.

_____ **Discuss** dilation with my doctor **if medically indicated**. This may add up to 35 minutes.

PERSONAL INFORMATION & DEMOGRAPHICS

Preferred Name: ___________________________ DOB:_____/_____/__________

Street Address: ___________________________ Sex: Male _____ Female____

City/State:_________________/____________ Zip Code: ____________________

Occupation: ______________________________ Hobbies: _____________________

Dominant hand: ◯ Right ◯ Left Sports you enjoy: ______________________

Preferred Number: _______________________ ◯ Mobile (text OK) ◯ Home ◯ Work

Email (PHR login): ____

Approximate height in feet & inches: _____' & _____" and weight in pounds: _______ lbs

Would you like to know if you are a good candidate for vision correction **without** eyeglasses, contact lenses, or eye surgery? ◯ Yes ◯ No

List any eye health concerns due to conditions of a grandparent or distant relative?
◯ No ◯ Yes, details: ____

FAMILY HISTORY:	**None**	Dad	Mom	Brother	Sister	Son	Daughter
Cancer:	◯	◯	◯	◯	◯	◯	◯
Unspecified Diabetes	◯	◯	◯	◯	◯	◯	◯
Type 1 Diabetes:	◯	◯	◯	◯	◯	◯	◯
Type 2 Diabetes:	◯	◯	◯	◯	◯	◯	◯
High Blood Pressure:	◯	◯	◯	◯	◯	◯	◯
Hyperthyroidism (high):	◯	◯	◯	◯	◯	◯	◯
Hypothyroidism (low):	◯	◯	◯	◯	◯	◯	◯
Cataract:	◯	◯	◯	◯	◯	◯	◯
Macular Degeneration:	◯	◯	◯	◯	◯	◯	◯
Glaucoma:	◯	◯	◯	◯	◯	◯	◯

SOCIAL HISTORY:

Do you drink alcohol? ◯ No ◯ Socially ◯ >2drinks/day ◯ >5/day

Do you use recreational drugs? ◯ No ◯ Yes, details: ________________________

Are you a current smoker? ◯ No ◯ Yes, how many cigarettes?
◯ < 4 cigs/day ◯ <1pack/day ◯ 1-2 ◯ >2

If you used to smoke, for many years?_____ & how long ago did you quit?___________

COMPREHENSIVE REVIEW OF SYSTEMS (PERSONAL HEALTH HISTORY)

Constitution:
__ **None known**
__ Developmental Disabilities
__ Cancer
__ Fatigue Syndrome
__ Other:

Ear / Nose / Throat:
__ **None known**
__ Hearing Loss
__ Sinusitis
__ Dry Mouth
__ Laryngitis
__ Other:

Neurological:
__ **None known**
__ Multiple Sclerosis
__ Epilepsy
__ Cerebral Palsy
__ Tumor
__ Stroke
__ Migraine
__ Autism Spectrum Disorder
__ Other:

Psychiatric:
__ **None known**
__ Depression
__ Attention Deficit
__ Anxiety Disorder
__ Bipolar Disorder
__ Other:

Cardiovascular:
__ **None known**
__ Hypertension (high blood pressure)
__ Aneurysm
__ Heart Disease
__ Vascular Disease
__ Congestive Heart Failure
__ Other:

Respiratory:
__ **None known**
__ Asthma
__ Bronchitis
__ Emphysema
__ Chronic Obstruction
__ Sleep Apnea
__ Other:

Gastrointestinal:
__ **None known**
__Crohn's
__ Colitis
__ Ulcer
__ Acid Reflux
__ Celiac Disease
__ Other:

Genitourinary:
__ **None known**
__ Kidney Disease
__ Prostate Disease / Cancer
__ Benign Prostatic Hypertrophy
__ Pregnant or Nursing
__ Herpes
__ Chlamydia
__ Other:

Musculoskeletal:
__ **None known**
__ Arthritis
__ Fibromyalgia
__ Muscular Dystrophy
__ Ankylosing Spondylitis
__ Osteoporosis
__ Gout
__ Other:

Allergies (drug & environmental):
__ **None known**
____
____
____
____

Integumentary:
__ **None known**
__ Eczema
__ Rosacea
__ Psoriasis
__ Herpes Simplex / Cold Sores
__ Herpes Zoster / Shingles
__ Other:

Endocrine:
__ **None known**
__ Type 2 Diabetes Mellitus
__ Type 1 Diabetes Mellitus
__ Thyroid Dysfunction
__ Hormonal Dysfunction
__ Other:

Hematologic / Lymphatic:
__ **None known**
__ Anemia
__ Large-volume blood loss
__ Ulcer
__ High Cholesterol
__ Other:

Allergy / Immunology:
__ **None known**
__ Rheumatoid Arthritis
__ Lupus
__ Sjogren's Syndrome
__ Other:

Current Medications:
__ **None known**
____
____
____
____
____
____
____
____
____
____

Eyes:
__ **None known**
__ Cataract
__ Glaucoma
__ Macular Degeneration
__ Dry Eye Disease
__ Retinal Detachment
__ Worsening floaters
__ Flashes of light
__ Refractive Surgery (LASIK)
__ Cataract Extraction
__ Corneal Transplant
__ Strabismus (cross-eye) Surgery