Welcome to Private Eyes Optical

First Name_____ Last Name_____
Address _____
City _____ State _____ Zip _____Sex: male / female
Date of Birth _____ Age: _____ *If female, are you pregnant? Yes/ No
Occupation: _____
Home Phone#: _____ Work Phone #: _____
Cell Phone #: _____E-mail Address: _____
When was your last eye exam? Date _____ Doctor _____
Do you wear glasses currently? Yes/ No Do you wear contact lenses? Yes/ No
If so, are your lenses: rigid/ soft
What brand/power/BC (if known): _____
How often do you replace? _____
Do you sleep in your lenses? Yes/ No

Are you interested in Contact Lenses today? Yes/ No
Are you interested in LASIK surgery? Yes/ No
Are you having any trouble with your eyes or vision? _____
Have you ever had an injury or surgery to your eyes? _____

Do you have:	Itching	Y	N	Eye Pain	Y	N
	Tearing	Y	N	Mucous discharge	Y	N
	Redness	Y	N	Sandy/gritty feeling	Y	N
	Dryness	Y	N	Light sensitivity	Y	N
	Lazy eye	Y	N	Double vision	Y	N
	Glare	Y	N	Flashes of light	Y	N
	Floaters or spots	Y	N	Glaucoma	Y	N
	Retinal hole or tear	Y	N	Macular Degeneration	Y	N
	Cataracts	Y	N	(Other) _____	Y	N
Do you have:	Diabetes	Y	N	High Blood Pressure	Y	N
	High Cholesterol	Y	N	Heart Problems	Y	N
	Thyroid Trouble	Y	N	History of a stroke	Y	N
	Cancer (type:_____)	Y	N	Respiratory Problems	Y	N
	Gastrointestinal	Y	N	Migraines	Y	N
	Depression/Anxiety	Y	N	(Other)_____	Y	N

Family History: Do any blood relatives have any of the following conditions?

Diabetes	Y	N	High Blood Pressure	Y	N
Heart Disease	Y	N	Cancer	Y	N
Glaucoma	Y	N	Macular Degeneration	Y	N
Retinal Detachment	Y	N	Blindness	Y	N

Please list all medications you are currently taking:_____
_____
_____
Please list any medical **allergies**:_____

Please complete the back -→

I Wellness Exam

Our office is equipped with the very latest in technology. The I-Wellness exam uses Optical Coherence Tomography to screen for many retinal issues. This instrumentation allows Dr. McConnell to look at cross sections of the back of the eye to determine the health of the Optic Nerve and Macula area. The I Wellness can aid Dr. McConnell in detecting early signs of Glaucoma, and various conditions of the macula. The I- Wellness exam allows for early diagnosis and treatment of conditions that would be UNDETECTED on a routine exam.
THE I Wellness Exam IS AN ADDITIONAL $ 25.00. Medical and Vision Insurance Will NOT Cover the I Wellness Exam.

Please indicate your preference:
_____ I would like to have the I-Wellness exam performed today.
_____ I would like to decline the I-Wellness exam at this time.

Signature _____ Date _____

Dilation Consent

A complete eye examination includes assessing the health of the internal ocular structures. Eye drops are used to open up the pupils, so Dr. McConnell may have a more complete view to evaluate your ocular health. You may experience some blurred vision, especially at near, as well as some sensitivity to light. These symptoms usually disappear within two to six hours. Some patients prefer to have a driver with them. We will provide you with temporary sunglasses after your examination to make you more comfortable.
Please indicate your preference:
_____ I consent to dilation.
_____ I refuse dilation.
_____ I will return for dilation at a later time.

Signature _____ Date _____

INSURANCE INFORMATION: INSURANCE MUST BE PRESENTED BEFORE SERVICES ARE RENDERED.
Insurance Name _____
Group or Policy # _____SS# _____
I, the undersigned (or my dependent) request payment of authorized insurance benefits be made on my behalf to Dr. McConnell for services rendered. I hereby authorize the doctor to release all information necessary to secure the payment of benefits.
Insurance Disclaimer: A quote of benefits and/or authorization does not guarantee payment or verify eligibility. Payment of benefits are subject to all terms, conditions, limitations, and exclusions of the member's contract at time of service.
Beneficiary Agreement: I understand that my Health or Vision insurance company may deny or revoke payment for the services received. If my Health/Vision Insurance company denies or revokes payment, I agree to be personally and fully responsible for payment. I also understand if my health insurance company does make payment for services, I will be responsible for any co-payment, deductible, or coinsurance that applies.

Signature _____ Date _____