WELCOME TO MILE HIGH EYE CARE

Today's Date_____ First Visit (Y/N)____

Patients Name_____ Sex (M/F)_____ Age_____ Date of Birth___/___/___
Social Security # (for insurance) _____-_____-_____ **Email Address** _____
Phone_____ Alternate Phone_____
If Married, Spouses Name_____
If under 18, Parents Name_____
Address_____ City_____ State_____ Zip_____
Employer/School_____ Occupation_____

Vision Insurance Plan_____ Vision Plan Primary Member_____
DOB of Primary Insured_____ SSN of Primary Insured_____
Health Insurance (insurance company and plan #) _____
If **Medicare** do you have supplemental coverage or medigap?_____

Date of Last Eye Exam _____ Where _____ Previous Eye Doctor Name_____
Do You Wear Contact Lenses? Yes/No Type_____ Are you interested in contact lenses? Yes/No
Reason for Today's Visit_____
List Activities/Hobbies_____
How Many Hours Per Day Do You Spend On Computers?_____
How Were You Referred to Our Office?_____

MEDICAL HISTORY:

Primary Medical Doctor Name _____ Date of Last Visit_____

Do you Have Any of The Following Conditions: ☐ **I Have No Medical Conditions**

☐Anxiety	☐Fibromyalgia	☐Kidney Disease	☐Stroke
☐Arthritis	☐Frequent Headaches	☐Liver Disease	☐Tuberculosis
☐Asthma	☐Heart Disease	☐Lung Disease	☐Tumors/Growths
☐Auto Immune Disorder	☐Hepatitis	☐Multiple Sclerosis	☐Ulcers
☐Cancer	☐Herpes	☐Osteoporosis	☐Venereal Disease/STD
☐Chronic Pain	☐High Cholesterol	☐Pregnant/Nursing	☐ Other_____
☐Depression	☐High Blood Pressure	☐Rosacea	_____
☐Diabetes (1 or 2)	☐Hyperthyroid	☐Shingles	_____
☐Epilepsy or Seizures	☐Hypothyroid	☐Sinus Problems	

Please List Current Medications That You Are Taking

_____
_____
_____

Do You Have Any Known Allergies To Medications? ☐Yes (please list below) ☐No

_____

Smoking History/Substance Use:
☐Current Smoker: Packs per Day_____ ☐Previous Smoker: Date Quit_____ or ☐Never Smoked
☐Drink Alcohol ☐Use Drugs

Does Anyone in the Family Have? ☐ **I Have No Family History of Medical Conditions**

☐Diabetes	☐Cancer	☐ Family History Unknown
☐Heart Disease	☐High Blood Pressure	☐Other_____

OCULAR HISTORY:
Have You Ever Had Surgery On One or Both Eyes? ☐ Yes (please list procedure and date below) ☐No

_____

Do You Have or Have You Ever Had? ☐**I Have No History of Ocular Conditions**

☐Macular Degeneration	☐Retinal Detachment	☐Eye Itching	☐Eye Fatigue
☐Amblyopia (lazy eye)	☐Dry Eye	☐Eye Watering	☐Strabismus (eye turn)
☐Cataracts	☐Flashes of light	☐Eye Redness	
☐Glaucoma	☐Floaters	☐Eye Trauma	

Family Eye Health History

Does anyone in your family have? ☐**I Have No Known Family History of Eye Conditions**
(list relationship for all that apply)

☐Glaucoma :_____ ☐Diabetic eye disease:_____
☐Macular Degeneration :_____ ☐Lazy Eye/Eye Turn:_____
☐Cataracts:_____ ☐Retinal Disease:_____
☐Blindness: _____
☐Other Eye Conditions:_____

Dilation of the Eyes

It may be necessary to dilate your pupils to perform a complete and thorough eye examination. This allows the doctor to obtain a better view of the back of your eye (the retina). The dilating drops typically last 3-4 hours. During this time you may find it difficult to focus at near, and less commonly at distance. You will be more sensitive to light. You will be provided with post-dilation sunglasses. We strongly recommend caution when driving or operating equipment. If you feel that you would not be able to drive or return to work, we can reschedule the dilation portion of your exam. Signing this section signifies that you have been informed of the risks and benefits of dilation.

Please Select One of the Options Below, Indicating Your Choice for Dilation:

☐I wish to have my eyes dilated at today's exam

☐I wish to have a dilation schedule for another day

☐I do not wish to have my eyes dilated and assume the responsibilities of having an eye exam with out dilation

Signature (Patient or Guardian)_____ **Date**:_____

Acknowledgement Notification of Privacy Policies

Signing this section signifies that you have received a copy of our Notice of Privacy Practices
(a copy is posted on the wall in the reception area, you may also have a copy for your records upon request)

In the course of providing service to you, we create, receive, and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for these services, and to conduct healthcare operations involving our office. The *Notice of Privacy Practices* you have been given describes these uses and disclosures in detail. Your personal information will not be used without your consent.

Signature (Patient or Guardian)_____ **Date**:_____

In the event that it becomes necessary for us to release your records to or request your records from another healthcare professional, I authorize Mile High Eye Care, and/or any of their associates to release and/or request these records. If applicable, I request that payment of authorized Medicare or other insurance be made either to me or on my behalf to Mile High Eye Care, and/or any of their associates for any services rendered to me. I authorize pertinent medical information about me to determine insurance benefits and billing to be released to the health care financing or other insurance agencies.

I UNDERSTAND I AM RESPONSIBLE FOR ANY CHARGES NOT COVERED BY MY INSURANCE COMPANY.

It is the policy of this office to require insurance co payments at time of service as well as:

1) Payment in full or at least one-half before the order can be placed
2) The balance of the fee must be paid at the time the order is dispensed
3) All orders are final when placed.

Signature (Patient or Guardian):_____ **Date**:_____