


Waterford Lakes Eye Care

Dr. Vijay Nair

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Welcome to Waterford Lakes Eye Care. Please take a few moments to provide us with information about yourself, your health, and your visual needs so we can better serve you.

Last Name: _____ **First** _____ **M.I.** _____ **Today's Date:** _____

Preferred Name: _____ (**Gender:** M F) **Occupation:** _____

Marital Status: Single Married Divorced Widow **Communication Preference:** Email Phone Postal

Address: _____ **Cell Phone:** _____

City: _____ **State:** _____ **Zip:** _____ **Work Phone:** _____

Date of Birth: ___/___/___ **Age:** _____ **SSN** _____ - _____ - _____ **Referred by:** _____

Email (legible): _____ **Parent/Guardian (if applicable)** _____

Date of last eye exam: ___/___/___ **Location and Doctor of last exam:** _____

Preferred Language: English Spanish French Japanese

Race: American Indian Asian Black or African American Hispanic Native Hawaiian White

Ethnicity: Hispanic or Latino Native Hawaiian or other Pacific Islander Not Hispanic or Latino

Primary Care Physician: _____ **Reason for today's visit:** _____

Insurance Information

Vision Plan (Routine vision, glasses and contacts)

Primary's Name: _____ Primary's DOB: ___/___/___

Name of Plan or Insurance: _____ Primary's Employer: _____

Member ID or SSN Number: _____

Medical Insurance (Eye infections, injuries, glaucoma, etc)

Primary's Name: _____ Primary's DOB: ___/___/___

Name of Plan or Insurance: _____ Primary's Employer: _____

Member ID or SSN Number: _____ Group Number: _____

Eye History

Do you now wear glasses? YES NO If yes, how old are they? _____

How is your vision with them? _____ Are they comfortable? _____

What type? Readers Distance Bifocal Trifocal Progressive (no line bifocal)

Are you interested in contact lenses **OR** renewing your contact lens prescription?

Yes (*additional fees involved*) NO (no contact lens prescription exam done, only glasses exam)

***If you currently wear contacts and do not renew your prescription, you will NOT be able to order any more contacts without a contact lens renewal exam.**

What type and brand? _____ How many hours/day? _____

When do you replace them? _____ Are they comfortable? _____

Do you use a computer? YES NO How many hours per day? _____

Are you having any visual problems related to computer usage? _____

What Hobbies, activities, and/or sports do you enjoy? _____

Are **YOU** experiencing any of the following visual symptoms? (Check all that apply)

- | | | |
|---|--|---|
| <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Light Sensitivity | <input type="checkbox"/> Loss of Night Vision |
| <input type="checkbox"/> Burning Eyes | <input type="checkbox"/> Itchy, Watery Eyes | <input type="checkbox"/> Reduced Side Vision |
| <input type="checkbox"/> Excessive Tearing | <input type="checkbox"/> Dry, Gritty Feeling | <input type="checkbox"/> Halos around Lights |
| <input type="checkbox"/> Noticeable Redness | <input type="checkbox"/> Pain or Discomfort | <input type="checkbox"/> Double Vision |
| <input type="checkbox"/> Old Floaters/Spots; how long and often _____ | | |
| <input type="checkbox"/> Old Flashes or Flickers of light; how long and often _____ | | |
| <input type="checkbox"/> New Floaters/Spots; how long and often _____ | | |
| <input type="checkbox"/> New Flashes or Flickers of light; how long and often _____ | | |

Have **YOU** ever been diagnosed with, or treated for, any of the following ocular conditions?

- | | | |
|---|--|---|
| <input type="checkbox"/> Retinal Detachment | <input type="checkbox"/> Eye Infections | <input type="checkbox"/> Lazy or Turned Eye |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Styes, Inflamed Lids |
| <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Disease of Retina | |

List any previous surgeries or injuries to your eyes:

List eye medications: _____

Medical History

List allergies to medications: _____

List any prescription or OTC (over the counter) medicines:

Please list any previous injuries, surgeries, or hospitalizations: _____

Are you pregnant or nursing? YES NO If pregnant, what is your due date: _____

Have **YOU** been diagnosed with or treated for any of the following problems? (Check all that apply)

- | | |
|------------------------------|---|
| Allergy | <input type="checkbox"/> Food <input type="checkbox"/> Other _____ |
| Genitourinary | <input type="checkbox"/> Bladder Infection <input type="checkbox"/> Kidney Stones |
| Musculoskeletal | <input type="checkbox"/> Arthritis <input type="checkbox"/> Joint Pain <input type="checkbox"/> Muscle Pain |
| Cranial/Facial | <input type="checkbox"/> Dry Mouth <input type="checkbox"/> Chronic Cough <input type="checkbox"/> Sinus Infection <input type="checkbox"/> Ear Infection <input type="checkbox"/> Hearing Loss |
| Neurological | <input type="checkbox"/> Headaches <input type="checkbox"/> Migraines <input type="checkbox"/> Seizures |
| Constitutional | <input type="checkbox"/> Fever <input type="checkbox"/> Weight Gain <input type="checkbox"/> Weight Loss <input type="checkbox"/> Dizziness/Fainting |
| Hematologic/Lymphatic | <input type="checkbox"/> Anemia <input type="checkbox"/> Clotting/ Bleeding Disorders |
| Psychiatric | <input type="checkbox"/> Depression <input type="checkbox"/> ADD/ADHD <input type="checkbox"/> Alzheimer's/ Dementia |
| Gastrointestinal | <input type="checkbox"/> Crohn's/IBS/Colitis <input type="checkbox"/> Hepatitis <input type="checkbox"/> Gall Bladder <input type="checkbox"/> Ulcers |
| Immunologic | <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Syphilis <input type="checkbox"/> Lupus <input type="checkbox"/> Mononucleosis <input type="checkbox"/> Shingles |
| Respiratory | <input type="checkbox"/> Asthma <input type="checkbox"/> Chronic Bronchitis <input type="checkbox"/> Emphysema, COPD <input type="checkbox"/> Tuberculosis |
| Endocrine | <input type="checkbox"/> Diabetes (how long) _____ years <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Elevated Cholesterol |
| Cardiovascular | <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Heart Problems |
| Other Conditions | _____ |

Family Medical History

In your **IMMEDIATE FAMILY**, is there any history of the following conditions?

- | | | | |
|---|---------------------|---|---------------------|
| <input type="checkbox"/> Lazy or Turned Eye | Relationship: _____ | <input type="checkbox"/> Cataracts | Relationship: _____ |
| <input type="checkbox"/> Glaucoma | Relationship: _____ | <input type="checkbox"/> Macular Degeneration | Relationship: _____ |
| <input type="checkbox"/> Retinal Detach/Disease | Relationship: _____ | <input type="checkbox"/> Blindness (Cause?) | Relationship: _____ |
| <input type="checkbox"/> Other Eye Disease | Relationship: _____ | <input type="checkbox"/> Diabetes | Relationship: _____ |
| <input type="checkbox"/> High Blood Pressure | Relationship: _____ | <input type="checkbox"/> Heart Disease | Relationship: _____ |
| <input type="checkbox"/> Arthritis | Relationship: _____ | <input type="checkbox"/> Cancer | Relationship: _____ |
| <input type="checkbox"/> Kidney Disease | Relationship: _____ | <input type="checkbox"/> Lupus | Relationship: _____ |
| <input type="checkbox"/> Thyroid Disease | Relationship: _____ | | |

Social History

- Do you drive? YES NO If YES, are you having any visual difficulties? _____
- Do you use tobacco products? YES NO If YES, how often? _____
- Do you use alcohol? Yes NO If YES, how often? _____
- Do you have a history of drug or alcohol abuse? YES NO If YES, how long? _____
- Have you ever been exposed to HIV or other sexually transmitted diseases? YES NO

Dilation Consent

For an optimal internal eye health evaluation, this office feels that most patients should have their eyes examined with the use of eye drops to dilate the pupils. Dilated pupils will cause the eyes to be light sensitive and the vision to be blurred especially for reading tasks. Driving may be difficult and should be done with extreme caution. Most patients will have no problem with the drops if they avoid reading and wear protective sunglasses for about four hours.

- I agree to have my eyes dilated today.
- I cannot have my eyes dilated today, but will reschedule this procedure at a later date.
- I do not agree to have my eyes dilated.

HIPAA Notice and Acknowledgement

Notice is located on laminated page on clipboard

I acknowledge that I have been provided the HIPAA Notice of Privacy Practices Yes No

Acknowledgements and Signature

I acknowledge that the health and insurance information I have provided above is true and correct to the best of my ability. I authorize payment of any vision or medical benefits I may be eligible for directly to Waterford Lakes Eye Care. **I agree that if my employer, insurance carrier, or plan sponsor denies payment to all or any part of my claim, I will be financially responsible for all outstanding charges.** I acknowledge that authorization obtained at the time of service does not guarantee payment, and any services not covered by insurance will be billed to me. In the event that I incur any unpaid balances, I agree to pay any collection fees, reasonable attorney fees, filing fees, and any other unpaid balances associated with my account. I have read the conditions of service, and as the patient or the patient's authorized representative I hereby accept these terms.

All orders of eyewear are custom ordered. There are no refunds or exchanges.

Signature of patient or
responsible party _____

Date: _____

iWellnessExam™ (OCT) and Digital Retinal Imaging (DRI)

Sight threatening diseases such as glaucoma, macular degeneration, diabetic retinopathy and others often have **no outward signs or symptoms in early stages**, which is why eye exams, including a thorough retinal evaluation, are important to protect vision. Dr. Nair has incorporated the **iWellnessExam™ (OCT) AND Digital Retinal Imaging (DRI)** as part of our comprehensive eye exam in effort to provide patients with state of the art care, the latest technology and medical innovations thorough eye exam.

iWellnessExam™ (OCT) is like an **MRI** of the eye but taking only seconds to perform. This scan provides high definition (**3D**) cross sections of your retina and optic nerve which can reveal signs of disease in great detail that are invisible to traditional examination methods. **See laminated color copy of sample images.**

Digital Retinal Imaging (DRI) captures comprehensive digital images of the surface of the retina. It combines the technology of retinal photography and computerized digital imaging to produce remarkably clear retinal images. **See laminated color copy of sample images.**

Together these unique technologies can help detect potentially vision threatening and systemic diseases in their very early stages. They also provide your doctor with a permanent baseline record of your retinal examination for comparison during future exams.

Our technician will perform these two tests and Dr. Nair will review them with you during your examination. The charge for both tests is \$39.00. **The \$39.00 charge is typically not covered by your medical or vision insurance; therefore, the cost will be added separately in today's visit.**

It is recommended by Dr. Nair that everyone has both tests done for the reasons mentioned in this form. He will personally review the images with you and answer any questions you have after his assessment of the images.

- I understand the vital importance of these tests and accept responsibility for the additional payment of \$39 today.
- I decline these tests against medical recommendation.