High resolution retinal imaging and visual field testing is part of Choice Eye Care, Ltd's vision exam. These medical tests provide an opportunity for the doctor to evaluate the health of your eye.

Choice Eye Care, Ltd will file a medical insurance claim for these tests to your insurance company. Choice Eye Care, Ltd. does not guarantee payment from any individual's insurance. You will be responsible for any copays and non-covered charges.

I authorize my Choice Eye Care, Ltd. provider to release any information necessary, including, but not limited to, the diagnosis and treatment rendered to myself and/or my dependents to third party payors , health practitioners and family members. If there is anyone who is not to receive my medical information I will notify Choice Eye Care, Ltd.

I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents. I will also be responsible for all collection fees. There will be a $30.00 charge on any returned checks.

SIGNATURE:_____

SIGNATURE OF PARENT IF MINOR:_____

RESPONSIBLE PARTY'S SOCIAL SECURITY NUMBER:_____

RESPONSIBLE PARTY'S NAME:_____

Welcome Back to Choice Eye Care

Date:_____ Employer_____/Occupation_____/Retired?

Name: _____ Current Flu Vaccine? Y N Current Pneumonia Vaccine? Y N

Has any of the following information changed since the last time we saw you?

Address _____City/State/Zip_____ Smoking Status Current/Former/Never

Phone _____ New Allergies _____

E-Mail Address _____ Pregnant/Planning A Pregnancy? Y/N

Medical Health Changes _____ Use of a C-PAP machine? Y/N

If Diabetic: Type I or Type II Recent A1C_____ Travel to West Africa Y/N

Please list all medications currently used, including over the counter and supplements:

****We can copy your written list.** Please initial here if you do not use any medications:_____

Medication_____ Purpose/Dosage_____/_____ How Long?_____

Medication_____ Purpose/Dosage_____/_____ How Long?_____

Medication_____ Purpose/Dosage_____/_____ How Long?_____

Medication_____ Purpose/Dosage_____/_____ How Long?_____

Medication_____ Purpose/Dosage_____/_____ How Long?_____

Medication_____ Purpose/Dosage_____/_____How Long?_____

DO YOU CURRENTLY HAVE OR ARE BEING TREATED FOR ANY OF THE FOLLOWING CONDITIONS?

Please indicate Yes and circle condition or No on each line.

VISION (e.g. eye pain, tearing, redness, vision loss, dry eye, flashes, floaters)…_____

CHRONIC FEVER, WEIGHT LOSS/GAIN, FATIGUE… _____

EAR/NOSE/THROAT PROBLEMS (e.g., hearing loss, sinus, sore throat)… _____

ENDOCRINE (e.g. **diabetic**, thyroid) … _____ Diabetes Type I/Type II A1C_____

HEART PROBLEMS (e.g., chest pain, irregular heartbeat, angina, mitral valve, **high blood pressure**)… _____

HEMATOLOGICAL (e.g., blood problems, **high cholesterol**, anemia, hepatitis, bleeding)… _____

RESPIRATORY PROBLEMS (e.g., shortness of breath, wheezing, coughing, congestion)… _____

GASTROINTESTINAL (e.g., heartburn, abdominal pain, diarrhea, vomiting)… _____

URINARY PROBLEMS (e.g., pain or discomfort, blood in urine)… _____

SKIN PROBLEMS (e.g., rashes, excessive dryness, eczema, rosacea, acne)… _____

MUSCULOSKELETAL (e.g., muscle aches, joint pain, swollen joints, arthritis)… _____

NEUROLOGIC (e.g., numbness, weakness, headaches, paralysis, seizures, stroke)… _____

PSYCHIATRIC (e.g., depression, anxiety, insomnia)… _____

Explanations, if needed:_____

Please complete other side as well.

Thank you.