Brilliant Eye Doctors / Patient Intake Form

Please print and write as legibly as possible. **Fill out every question.**

Name: ______________________ Date of Birth: ____/____/______ Date: __________

Address: ______________________ City: ______________ State: ____ Zip Code: ______

Phone Number: ______________ E-mail: ______________________________

Occupation: ____________ Employer: ______________ Insurance(s): ______________

Last Eye Exam: __________ Doctor: __________ Last Medical Exam: __________ Doctor: __________

PAST OCULAR HISTORY: (Please check if you have/have had any of the following)

___ Eye Infection ___ Eye Injury ___ Cataracts ____ Cataract surgery ___ Strabismus surgery ___ Amblyopia

___ Macular degeneration ____ Glaucoma ___Refractive surgery ____ Other: ______________________

PAST MEDICAL HISTORY: (Please check if you have/have had any of the following)

___ Arthritis ___ Diabetes type 1 ___ Diabetes type 2 ___ GI problem ___ Headaches ____ Heart condition ____ HIV+

___ High cholesterol ____ High blood pressure ____ Respiratory disease ___ Thyroid disease Other: ______________

If you are diabetic, what year were you diagnosed?: ________ What is your most recent A1c: ______%

Are you allergic to anything (including medications)? □ No □ Yes Please list: ______________________

Are you taking any medications? □ No □ Yes Please list: ______________________________

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List all major injuries, surgeries, or hospitalizations: ______________________________

Are you pregnant and/or nursing? □ No □ Yes How many weeks pregnant:______________________

Do you use tobacco products? □ No □ Yes Type/Amount/How long: ______________________

Do you drink alcohol? □ No □ Yes Type/Amount/How often: ______________________

Do you use recreational drugs? □ No □ Yes Type/Amount/How often: ______________________

FAMILY HISTORY: (Please note any family history including parents, grandparents, siblings, children, living or deceased)

CONDITION	NO	YES	RELATIONSHIP	CONDITION	NO	YES	RELATIONSHIP
Cataracts	□	□	____________	Diabetes	□	□	____________
Glaucoma	□	□	____________	Heart disease	□	□	____________
Retinal detachment	□	□	____________	Hypertension	□	□	____________
Macular degeneration	□	□	____________	Cancer	□	□	____________
Amblyopia	□	□	____________	Kidney disease	□	□	____________
Diabetic retinopathy	□	□	____________	Other: ______________			____________
Blindness	□	□	____________				

OPTOMAP RETINAL IMAGING

Optomap retinal imaging captures 200° images of the retina **without the side effects of dilation drops.** Optomap is non-invasive and thoroughly evaluates for **retinal holes or detachments, ocular health changes related to high cholesterol or high blood pressure, diabetic retinopathy and other diseases which may lead to vision loss.**

Optomap is part of all routine eye exams at an additional fee of **$35**. Medical insurance **may** cover this test depending on your policy and/or existing medical conditions.

For some eye conditions, such as **floaters or flashes of light**, a dilated examination is **still required**. Dilation increases the in-office time by approximately 20 minutes and its side effects include blurred vision and sensitivity to light.

iWELLNESS SCAN

Do you or your family have glaucoma or macular degeneration? Do you have diabetes with vision changes?
Our iWellness scan takes a 3D image of the optic nerve and retina, similar to an ultrasound. It is a quick, painless scan that provides early detection, monitoring and treatment of eye diseases including **glaucoma, macular degeneration, and diabetic retinopathy**. This test is recommended for patients **over 50** or patients with family history of glaucoma or macular degeneration. The fee for iWellness scan is **$25**.

(Initials)__________ **Yes**, I do want to have iWellness scan done today.

(Initials)__________ **No**, I do not want to have iWellness scan done at this time. I do not hold Brilliant Eye Doctors and its employees liable for eye diseases which could have been detected by the iWellness scan.

VISUAL FIELD TESTING

Have you had a stroke? Do you or a family member have glaucoma? Is peripheral vision important for your job?
A visual field test checks for loss of sight or missing areas of vision, both centrally and peripherally. Visual field testing allows us to map the health of the nerve pathway and may aid in early detection in **glaucoma,** as well as detecting and monitoring damage from neurological conditions such as **strokes.** This is a non-invasive test that takes approximately 5 minutes for an additional fee of **$15**. Medical insurance **may** cover this test depending on your policy and/or existing medical conditions.

(Initials)__________ **Yes**, I do want to have a visual field screening today.

(Initials)__________ **No**, I do not want to have a visual field screening at this time. I do not hold Brilliant Eye Doctors and its employees liable for eye diseases which could have been detected by the visual field screening.

GENERAL ACKNOWLEDGEMENTS

1. I have read and understand Brilliant Eye Doctor's Notice of Privacy Practices Form.

2. I also understand that I have 60 days to return to the clinic with any concerns regarding my prescription at no charge. Any visits after the 60-day period may be subject to an additional examination fee due to possible changes in vision.

3. I understand that a quote of eligibility from my insurance is not a guarantee of payment. If my insurance does not pay as expected, I am ultimately responsible for all charges for services rendered to me on this day. I do not hold Brilliant Eye Doctors and its employees responsible if I am not eligible for benefits at the time of my visit.

______________________________ ______________________________
Patient Signature (or Guardian's Signature) Date