Today's Date:_____

CONCEPT VISION and Associates, LLC

WE ARE OUT - OF- NETWORK PROVIDERS FOR ALL VISION INSURANCE PLANS

Patient Information:

Name (Last)_____(First)_____Age_____ Date of Birth_____

Address_____City_____State_____ZipCode_____

Phone(Home)_____ (Cell)_____Email_____

Today's visit is for: ☐Routine Eye Exam ☐Contact Lens Fitting ☐Red Eye/Infection ☐Other **Previous Patient?**

MEDICAL HISTORY

Do **You** have any of the following?

- ☐ Diabetes
- ☐ Glaucoma
- ☐ Age related macular degeneration
- ☐ Past eye surgeries
- ☐ High blood pressure
- ☐ History of cancer
- ☐ Cataracts
- ☐ Strabismus (cross or wall eyed)
- ☐ Thyroid disease
- ☐ Are you pregnant or nursing?

List all the eye drops you are taking:

_____

Do your **Blood Relatives** have any of the following?

- ☐ Glaucoma
- ☐ Age related macular degeneration
- ☐ Eye cancers

Do you have any allergies to medicines?

List:_____

- ☐ Do you use computers 1 hour or more a day?
- ☐ Are you interested in trying contact lenses?

What is your Occupation/ Hobbies?

List:_____

Are you taking any medication?

List:_____

EYE HEALTH

Concept Vision strongly recommends a thorough examination of your retina each year. Early signs of many ocular and systemic diseases can appear in your retina before any noticeable symptoms. These diseases include **Diabetes, Macular Degeneration, Glaucoma, Hypertension, Retinal Detachments, Retinal Holes, and Cancer.** The Doctor is proud to offer the OPTOmap: a state-of-the-art digital retinal scanning technology that allows us to assess the health of your retina without the use of dilation drops.

OPTOmap Exam WILL BE PERFORMED ON EACH PATIENT TO REDUCE CONTACT AND OFFERS THE FOLLOWING:

- No blurred vision
- No light sensitivity
- Scan takes less than 1 second
- Digital Image can be reviewed /compared year after year
- You can see your retina with your doctor

☐ **I understand that todays out of pocket expense is $89 and contact lens evaluation fees are additional.**

I further agree to pay all applicable exam charges. **I understand that payment is due when professional services are rendered and are non-refundable. Any prescription change or change of contact lens brand after 3 months from the initial exam date will require a new exam at the full examination fee.** I agree that I have been given access to Concept Vision and Associates, LLC **Notice of Privacy Practices/ (HIPPA) Policies**.

Patient /Guardian's Signature: _____ Date: _____

Submit Form Print Form