

Madeira Optical

Patient Information

(Please Print)



PATIENT INFORMATION

Patient's Last Name		First	Middle	<input type="checkbox"/> Mr.	<input type="checkbox"/> Miss	Today's Date / /
				<input type="checkbox"/> Mrs.	<input type="checkbox"/> Dr.	
Street Address		City	State	Zip	Social Security #	Phone Numbers H: _____ M: _____
E-mail Address:						
Employer	Occupation or School Grade			Date of Birth / /		Age: _____ Gender <input type="checkbox"/> M <input type="checkbox"/> F
How may we contact you? (You can change any time)						
<input type="checkbox"/> Email (Primary Recall Method)		<input type="checkbox"/> Home Phone		<input type="checkbox"/> Mobile Phone		<input type="checkbox"/> Text Message

Please let us know how you heard about us:

INSURANCE INFORMATION *PLEASE PRESENT INSURANCE CARD AT THE RECEPTION DESK*

Primary Insured's Name	Insured's Social Security #	Insured's DOB	Policy #	Insurance Company
Patient's Relationship to Insured	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other
Patient's Marital Status	<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Other	
Patient's Employment Status	<input type="checkbox"/> Employed	<input type="checkbox"/> Student	<input type="checkbox"/> Part-time Student	<input type="checkbox"/> Other

VISUAL COMFORT *PLEASE CHECK ALL THAT APPLY*

<input type="checkbox"/> Light Sensitivity	<input type="checkbox"/> Artificial Light Sensitivity	<input type="checkbox"/> Difficulty Seeing at Night	<input type="checkbox"/> Eye Strain	<input type="checkbox"/> Glare
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CURRENT EYEWEAR INFORMATION

I Currently Wear Eyeglasses	<input type="checkbox"/> Yes	<input type="checkbox"/> No
How Old Are Your Eyeglass Lenses?	<input type="checkbox"/> Main/Dress ____ Years	<input type="checkbox"/> Back-up ____ Years
I Currently Wear Rx Sunglasses	<input type="checkbox"/> Yes	<input type="checkbox"/> No
I Currently Wear Contact Lenses	<input type="checkbox"/> Yes, Soft Contact Lenses/Disposable	<input type="checkbox"/> Yes, Rigid Gas Permeable
My Current Contacts are Comfortable	<input type="checkbox"/> Yes	<input type="checkbox"/> No
I am Interested in Trying Contacts	<input type="checkbox"/> Yes	<input type="checkbox"/> No

VISUAL DEMANDS *PLEASE LIST ALL ACTIVITIES THAT APPLY & DAILY TIME*

<input type="checkbox"/> Computer/Tablet/Phone ____ Hours	<input type="checkbox"/> Sports Activities	<input type="checkbox"/> Outdoor Activities
<input type="checkbox"/> Reading/E-readers ____ Hours	<input type="checkbox"/> Occupational Driving ____ Hours	<input type="checkbox"/> Work/Recreational Safety

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I have read and understand the privacy policy I signed on my first visit. I understand that this policy is available for review. I understand that I am financially responsible for any balance. I authorize Madeira Optical and my insurance company to release any information required to process my claims.

PATIENT / GUARDIAN SIGNATURE	PRINTED GUARDIAN NAME (if applicable)	DATE
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Medical History Questionnaire

Name:	Date:	Last Eye Exam:
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Do you have allergies to medication?	Y/N	If yes, please explain:
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Please list medications you take, including over the counter medications, oral contraceptives, aspirin, and home remedies:

List all major surgeries and/or hospitalizations you have had:

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

CONDITION/DISEASE	SELF	FAMILY HISTORY	RELATIONSHIP TO YOU
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

SOCIAL HISTORY *(This information is kept confidential. However, you may discuss this portion directly with the doctor if you prefer.)*

Yes, I would like to discuss my social history with my doctor. (check box)

	NO	YES		NO	YES
Are you pregnant or nursing?	<input type="checkbox"/>	<input type="checkbox"/>	Do you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>
Do you use tobacco products?	<input type="checkbox"/>	<input type="checkbox"/>	Do you take illegal drugs?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been exposed to or infected with:	<input type="checkbox"/>	Gonorrhea	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>
			<input type="checkbox"/>	HIV	<input type="checkbox"/>
					<input type="checkbox"/>
					<input type="checkbox"/>
					<input type="checkbox"/>

REVIEW OF SYSTEMS *(Please list any previous or current problems below)*

	NO	YES	?		NO	YES	?
CONSTITUTIONAL				ENDOCRINE			
Fever, Weight loss/Gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid/Other Glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
INTEGUMENTARY (Skin)				EAR, NOSE & THROAT			
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergies/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NEUROLOGICAL				Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dry Throat/Mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	RESPIRATORY			
EYES				Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	VASCULAR/CARDIOVASCULAR			
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sandy or Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	GASTROINTESTINAL			
Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	GENITOURINARY			
Excess Tearing/ Watering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genitals/Kidneys/Bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glare Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	BONES, JOINTS, MUSCLES			
Eye Pain or Soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Infection of Eye/Lid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eyestrain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Styes or Chalazion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	LYMPHATIC/HEMATOLOGIC			
Flashes in Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Floaters in Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Distorted Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ALLERGIC/IMMUNOLOGIC			
PSYCHIATRIC					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you answered YES to any of the above or have a condition not listed, please explain & list medication:

Dr. Malinda Pence & Assoc., Inc.

(1) Digital Retinal Image Screening

As part of your eye exam, we recommend a valuable diagnostic called Digital Retinal Image Screening. The doctor is concerned about retinal problems including Macular Degeneration and Glaucoma, as well as systemic diseases such as Diabetes, Stroke and High Blood Pressure. These conditions can lead to partial vision loss or blindness, and often can develop without warning and can progress without symptoms. Your digital image screening provides:

- High resolution baseline images of your retina, macula, optic nerve and blood vessels.
- A permanent record that is very valuable in assessing the health of your eyes and tracking any year over year changes in your eyes.
- The ability to view your digital image during your examination.



Healthy Eye



Diseased Eye

Retinal Image Screening is painless and is comparable to taking an annual baseline dental x-ray. Retinal images are especially important for those who have a personal or family history of **Glaucoma, Diabetes, High Blood Pressure, Retinal problems or a high prescription**. In addition to annual screenings, doctors may order medical retinal images as a component of the diagnosis and treatment of eye diseases, which may be covered by insurance.

The professional fee is **\$25** for screening images of both eyes due at the time of service. Most managed care plans do not cover this advanced screening option. Ask your doctors for details.

YES, I ELECT baseline a retinal screening and digital images added to my medical records.

NO, I DECLINE retinal image screening. The doctor may request images as part of a medical diagnosis.

(2) Patient Consent for Use & Disclosure of Protected Health Information

I hereby give my consent for Dr. Malinda Pence & Assoc., Inc. to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Dr. Malinda Pence & Assoc., Inc. Notice of Privacy Practices available at the office describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Dr. Malinda Pence & Assoc., Inc. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Dr. Malinda Pence & Assoc., Inc.

With this consent, Dr. Malinda Pence & Assoc., may contact my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Dr. Malinda Pence & Assoc., Inc. may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With this consent, Dr. Malinda Pence & Assoc., Inc. may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Dr. Malinda Pence & Assoc., Inc. restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Dr. Malinda Pence & Assoc. to use and disclose my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Dr. Malinda Pence & Assoc., Inc. may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Print Patient Name (And Legal Guardian Name if Applicable)

Date