Madeira Optical

RETURNING PATIENT UPDATE

(Please Print)

RETURNING PATIENT INFORMATION

Patient's Last Name	First	Middle	Today's Date
			/ /
Street Address			Home Phone No.

❑ **The above contact information is correct and my contact information has not changed**

❑ **The above information is incorrect, I will update this information in the gray box 1 below**

INSURANCE INFORMATION

PLEASE PRESENT INSURANCE CARD AT THE RECEPTION DESK

Primary Insurance Co.	Policy #

❑ **The above insurance information is correct and my insurance information has not changed**

❑ **The above information is incorrect, I will update this information in gray box 2 below**

VISUAL EXPERIENCE *(please check all that apply)*

❑ Blur - Distance	❑ Eye Redness	❑ Burning Sensation	❑ Eye Itching
❑ Blur - Near	❑ Dry Eye	❑ Tearing or Watery Eyes	❑ Loss of Side Vision
❑ Blur - Mid/Computer	❑ Difficulty Seeing at Night	❑ Headaches	❑ Double Vision
❑ Eye Pain	❑ Light Sensitivity	❑ Eye Strain	❑ Glare Sensitivity
❑ Halos	❑ Floating Spots in Vision	❑ Flashes of Light	❑ Sensitivity to Artificial Light

VISUAL DEMANDS *(please check all activities that you engage in while wearing eyewear)*

❑ Computer Work _____ Hours	❑ Sports Activities	❑ Outdoor Activities
❑ Detailed Reading _____ Hours	❑ Occupational Driving _____ Hrs	❑ Work in Safety Environment

CONTACT LENSES *(please check if applicable)*

My current contacts are comfortable ❑Yes ❑No	I would like to try contact lenses ❑Yes ❑No

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 also authorize Madeira Optical and my insurance company to release any information required to process my claims.

X _____

PATIENT/GUARDIAN SIGNATURE DATE

1. PATIENT'S NEW CONTACT INFORMATION

Street Address	City	State	ZIP Code	Home Phone No.

2. PATIENT'S NEW INSURANCE PLAN

PLEASE PRESENT INSURANCE CARD AT THE RECEPTION DESK

Insured's Name	Insured's S.S. #	Birth Date	Primary Insurance Co.	Policy #
		/ /		

Patient's Relationship to Insured ❑ Self ❑ Spouse ❑ Child ❑ Other

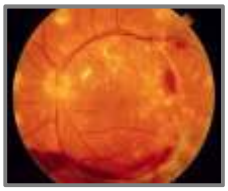
Dr. Malinda Pence & Assoc., Inc.

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.