My Optics of Little Silver Medical History-Returning Patient

Today's Date: ____________________

Name: ____

Date of Birth: ____

Have there been any changes to your address since your last visit? If yes, please update:

____

Have there been any changes to your vision and/or medical insurance? If yes, please update:

____

Reason for today's visit (Routine exam, contact lenses, blurry vision, pain, red eyes, etc):

____

Do you have any of the following:

	YES	NO
Headaches		
Double Vision		
Flashes		
Floaters		
Loss of Vision		
Blurred Vision		
Loss of Side Vision		
Dry Eye		
Tearing		
Itchy Eyes		
Red Eyes		
Sensitivity to Lights		
Eye Pain		
Discharge from Eyes		
Injury to Eyes		

Medical History Update:

Name of Primary Care Physician: ____

Date of Last Physical: ____

Most recent Height: _______________ Most recent Weight: _______________

Please list all medications and dose:

____

____

Please list all allergies: ____

Please Sign: ____

My Optics of Little Silver

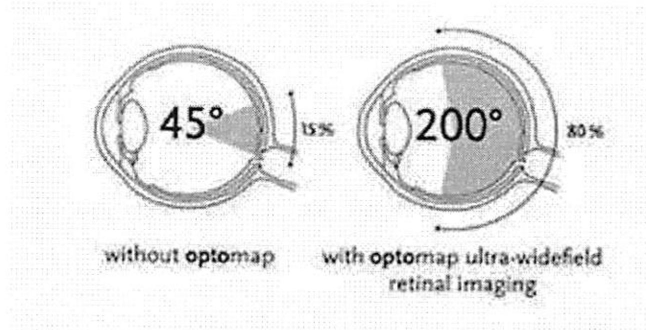
optomap®
Retinal Exam

We are excited to offer the latest technology available to evaluate the health of our patient's eyes

The Optos Daytona Plus provides an unequaled 200 degree view of your retina in a high-resolution, high-contrast digital image. This comprehensive view gives our doctors the opportunity to identify and follow peripheral retinal pathology much more easily. In **many** cases, we may **now avoid the strong dilating drops during the exam.**

Vision Threatening conditions possibly detected with an optomap include:

- Macular Degeneration
- Glaucoma
- Retinal Tears or Detachments
- Ocular melanoa/tumors
- Diabetes
- High Blood Pressure



Benefits of an Optos Scan include:

- No other retinal exam gives you a more extensive single-view scan.
- This scan takes only seconds to perform
- It does NOT REQUIRE DILATING drops
- It is PAINLESS and WILL NOT MAKE YOUR VISION BLURRY afterwards
- This scan becomes a part of your permanent record and enables your Doctor to make important comparisions at future exams.

An Optomap scan is a valuable tool in evaluating the health of your eyes. We feel strongly that it should be performed annually. The cost for the Optomap scan is $35 and may not be covered by your insurance unless there is pathology detected.

The **opto**map® Retinal Exam is fast, easy, and comfortable.

☐ I DO want the procedure performed.

☐ I DO NOT want the procedure performed. I would prefer a regular dilation.

____________________________   ____________
Signature   Date

____
Print name

Insurance Information

PATIENT INFORMATION: **DATE:**__________

Patient's Name: ________________________ M or F

Patient's Date of Birth: ______________ **Best Contact Number:** ________________________

Patient's Address: ____

PRIMARY MEDICAL INSURANCE:

Name of INSURANCE: ____

ID #: ______________________ **Patient's relationship to member:** o Self o Spouse o Child o Other

Member's Name: ____

Member's Date of Birth: ___________

Member's Address (if different than patient's)____________________________________

____

Member's Employer:____

PRIMARY VISION INSURANCE:

Name of INSURANCE: ____

ID #: ______________________________ **SS#** ________________________________

Relationship to Insured o Self o Spouse o Child o Other

Member's Name: ____

Member's Date of Birth: ___________

Member's Address (if different than patient's)____________________________________

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***** MOST VISION INSURANCES ARE SEPARATE FROM MEDICAL INSURANCES. Providing us with just your medical insurance information is often not enough to find out who covers your ROUTINE eye examination and materials (glasses and contact lenses). It is your responsibility to know you vision plan and provide us with the name and ID number. Please sign that you acknowledge this.**

Please sign: ____

TURN OVER FOR SECONDARY INSURANCE INORMATION

SECONDARY INSURANCE ○MEDICAL ○ VISION

Name of INSURANCE: ______________________________

ID #: ______________________ SS# ______________________

Patient's relationship to member: ○ Self ○ Spouse ○ Child ○ Other

Member's Name: ______________________________

Member's Date of Birth: __________

Member's Address (if different than patient's) ______________________________

____

TERTIARY INSURANCE: ○MEDICAL ○VISION

Name of INSURANCE: ______________________________

ID #: ______________________ SS# ______________________

Patient's relationship to member: ○ Self ○ Spouse ○ Child ○ Other

Member's Name: ______________________________

Member's Date of Birth: __________

Member's Address (if different than patient's) ______________________________

____

I AM AWARE THAT IF FOR ANY REASON THIS CLAIM IS DENIED BY MY INSURANCE AND THE INSURANCE DOES NOT PAY, I AM LIABLE FOR CHARGES FOR SERVICES RENDERED

Patient (Guardian) signature ______________________________