Total Eye Care

For A Lifetime of Healthy Vision

Drs. Steve and Samantha Beaty
662-862-6727

Welcome to Our Office

Name_____ Today's date_____ Date of last exam_____

Street_____ Date of birth_____ Age_____ Sex: Male/ Female

City_____ State_____ Zip_____ Spouse (or parent) name_____

Home phone_____ Spouse (or parent) work phone_____

Work phone_____ Medical insurance company_____

Social security number_____ Vision insurance company_____

Employer_____

Occupation_____

Email address_____

Medical History (see front desk if assistance is needed)

Cardiovascular: Heart disease___High blood pressure__stroke___
Respiratory: Asthma___Emphysema___Other_____
Gastrointestinal: Ulcer___Crohns___ Other_____
Genitourinary: Sexually transmitted disease___
Musculoskeletal: Osteoarthritis___fibromyalgia___ Other_____
Integumentary: ecxema___rosacea___psoriasis___Other_____
Neurologic/Psychiatric: Multiple sclerosis___depression___
Endocrine: Diabetes___(year of diagnosis_____)thyroid____
Hematological : Anemia___severe blood loss___Other_____
Allergic: Drug allergy___Environmental allergy___ rheumatoid arthritis___

Current medications:_____

_____

What type of *vitamin* do you take?_____

Are you allergic to any medications? _____ Are you pregnant? ___

Name of physician _____Pharmacy_____

Past Eye History

Eye surgery: No Yes Eye injury: No Yes Eye disease: No Yes

Details:_____

Social History

Do you drive? No Yes
Do you smoke? No Yes Do you drink alcohol? No Yes
Do you use illegal drugs? No Yes
Hobbies_____

Family Medical History

Glaucoma No Yes Macular Degeneration No Yes
Diabetes No Yes Other_____

How did you hear about our office?

☐Friend or relative. Who? _____

☐Another doctor. Who? _____

☐Yellow pages. ☐Newspaper advertisement.

☐Participating eye care plan. _____

☐Other _____

Do You. . . .

. . Have more than one pair of current glasses? No Yes
. . Have prescription sunglasses? No Yes
. . Have sunglasses that block 100% UV radiation? No Yes
. . Plan to select new eyewear today? No Yes
. . Work on a computer for long periods? No Yes
. . Want information on thinner, lighter lenses? No Yes
. . Spend time outdoors? (how much?) ____hrs/week
. . Wear bifocals? No Yes
. . (If yes, are you bothered by restricted windows, lines or head tilting?) No Yes
. . Find that there are times you'd rather not wear glasses? No Yes
. . Wear contact lenses? No Yes
If so, are you satisfied with vision and comfort? No Yes
Are you interested in a "test drive" of the latest in contact lens designs? No Yes
Have you worn contact lenses in the past? No Yes

Do You Experience. . .

Any discomfort with your eyes? No Yes
Watery Eyes? No Yes
Redness? No Yes
Grittiness? No Yes
Eye strain? No Yes
Blurry vision? No Yes
Problems with glare or reflection? No Yes
Sensitivity to light? No Yes
Headaches? No Yes
Floaters or flashes of light? No Yes

RESPONSIBLE PARTY

NAME_____

ADDRESS_____

_____

HOME PHONE NUMBER_____

SOCIAL SECURITY NUMBER_____

INSURANCE (MEDICAL/VISION)_____

EMPLOYER_____

EMPLOYER PHONE NUMBER_____

FINANCIAL AGREEMENT

I fully understand that I am ultimately responsible for **any and all charges** associated with my account. This also includes any **deductibles, co-payments, and any charges that insurance may not cover** if any insurance is filed on my behalf. If I fail to pay any amount due, I will also be responsible for all collection fees, court costs, attorney fees and any other charges incurred in the collection of any balance due.

SIGNED_____

DATE_____

HIPPA INFO RECEIVED INITIALS_____

Medical Testing Authorization

At Total Eye Care our goal is to take care of our patients' vision and eye health to the best of our ability. In order to do this we have incorporated **Digital Retinal Imaging** into our protocol for a comprehensive eye examination. This testing does not replace the need for dilation, however, it allows us instant views of your retina for evaluation today and comparison in the future. The **charge for this procedure is $30** and is recommended by our doctors to be done on an annual basis. . **Please select an option below and return this form to the front desk.**

_____ I wish to have Digital Retinal Imaging today.

_____ I understand that my doctor encourages Digital Retinal Imaging in order to best care for my eyes, however, I choose to **decline** this procedure today.

Patient Signature:_____