TODAY'S DATE:

FOR OFFICE USE ONLY: MRN #

Joseph & Swan Eye Center, APMC

Jonathan M. Joseph, MD ~ Kevin R. Swan, MD ~ Alexandra F. Sellers, MD ~ Meaghan Cortez Aridi, OD

WELCOME TO OUR OFFICE ~ PLEASE PRINT CLEARLY

Last Name: _____First Name: _____Middle Initial: _____

Date of Birth: _____ SEX: M F MARITAL STATUS: _____

LANGUAGE: _____RACE: _____SOCIAL SECURITY #: _____

ETHNIC GROUP: (CIRCLE ONE) unspecified, declined to specify, prohibited by state law, Hispanic or Latino, not Hispanic or Latino, unknown

HOME PHONE: _____CELL PHONE: _____ PREFERENCE: CELL OR HOME

EMAIL: _____

ADDRESS: _____

CITY: _____ STATE: _____ZIP: _____

AUTHORIZATION TO DISCUSS PROTECTED HEALTH INFORMATION/EMERGENCY CONTACT:

I give the Joseph & Swan Eye Center permission to release medical information to the following individuals:

Name: _____Relationship: _____Phone: _____

Name: _____Relationship: _____Phone: _____

IF MINOR, LIST PARENT OR GUARDIAN'S NAME:_____

DOB: _____ RELATIONSHIP TO PATIENT: _____

PATIENT MEDICAL HISTORY QUESTIONNAIRE

PRIMARY CARE: _____CARDIOLOGIST:_____

DIABETIC PHYSICIAN:_____YEARS DIAGNOSED AS DIABETIC: _____

A1C LEVEL: _____FASTING BLOOD SUGAR: _____

WRITE YES OR NO: PNEUMONIA VACCINE: _____ ALCOHOL USE: _____ SMOKER: _____

TOBACCO USE: _____ CONTACT LENS WEARER: _____ IF YES TYPE (HARD OR SOFT): _____

PREFERRED PHARMACY & LOCATION: _____

ANY CURRENT MEDICATIONS: _____

_____

_____

ANY DIAGNOSED MEDICAL CONDITIONS: _____

_____

ANY PAST SURGERIES: _____

_____

ANY ALLERGIES: _____

ANY EYE ISSUES DO YOU WANT TO DISCUSS WITH YOUR DOCTOR: _____

DILATION CONSENT

Dilation is necessary to perform a complete eye exam of the retina and back of the eye. This may reveal the presence of a serious systemic condition as well as eye conditions. You may require driving assistance until the drops wear off. Risks include blurred vision after dilation until drops wear off, glare and distorted vision until drops wear off, In rare cases extreme elevation of the eye pressure can occur, allergic reaction can occur, increased blood pressure, cardiac arrhythmias, tachycardia, dizziness, increased swelling.

Please inform us immediately if any of these rare side effects occur.

I authorize my physician and staff to administer dilating eye drops.

PLEASE INITIAL: _____

REFRACTION

An essential piece of medical information that is used to assess your eyes and search for medical conditions and vision problems. It can also be used to provide a current eyeglass prescription, if necessary. The doctor determines if a refraction is needed. This is a non-covered service by Medicare and many other insurance plans.

By initialing I accept full responsibility for this service and the $45 fee is collected at the time of service.

PLEASE INITIAL: _____

***We do not accept Medicaid* please see front for ABN form/cash pricing**