CLEARPOINT VISION

Welcome to our office! ☺

clearpointvision.com - **online appointments**

PATIENT DEMOGRAPHICS	
First: Middle: Last:	Date of birth: / /
Address:	Age: Sex: M F
City: State: Zip:	Social Security: - -
Home Phone: Cell Phone:	Email:
Occupation: Employer:	Referred by:

OCULAR AND MEDICAL HISTORY

Chief Medical Complaint: ☐ Poor Distance Vision ☐ Poor Near Vision ☐ Both

☐ Other: _____

Date of Last EYE EXAM / Name of Last Eye Doctor

/ /

Date of Last Physical Exam / Primary Physician

/ /

Interested in Contacts?	☐ Yes	☐ No	Interested in LASIK SUGERY?	☐ Yes	☐ No
Do you currently wear:	☐ Glasses	☐ Contacts	Problems with your contacts?	☐ Yes	☐ No

REVIEW OF SYSTEMS

Please check off *any* Medical Conditions that apply to YOU: ☐ ALL NORMAL

General/Constitutional:	☐ Fever or Chills	☐ Weight loss /gain	☐ Insomnia	☐ Fatigue	
Ear/Nose/Mouth/Throat:	☐ Allergies	☐ Sinus	☐ Cough	☐ Dry Mouth	☐ Sore throat
Cardiovascular:	☐ Heart Disease	☐ High Cholesterol	☐ High Blood Pressure	☐ Diabetes	
Respiratory:	☐ Asthma	☐ Bronchitis	☐ Emphysema	☐ COPD	
Gastrointestinal:	☐ Diarrhea	☐ Constipation	☐ Heartburn	☐ Swallowing Difficulties	☐ Change in appetite
Genitourinary:	☐ Frequent Urination	☐ Urinary Tract Infection	☐ Hernia / Kidney Stones		
Musculoskeletal:	☐ Rheumatoid Arthritis	☐ Muscle Pain	☐ Joint Pain		
Integumentary (skin):	☐ Eczema	☐ Rashes	☐ Dryness	☐ Itching	☐ Hair and Nail Changes
Neurological:	☐ Headaches	☐ Migraines	☐ Seizures		
Psychiatric:	☐ Agitated	☐ Memory Loss	☐ Depression	☐ Mood Swings	☐ Suicidal Thoughts
Endocrine:	☐ Thyroid	☐ Other Glands _____			
Lymphatic / Hematological:	☐ Anemia / Bleeding problems	☐ Ease of Bruising			
Allergic / Immunologic:	☐ Food Allergies	☐ Pollen / Dust			

MEDICATIONS AND ALLERGIES

Medications: (including eyedrops)

Allergies: (meds, food, seasonal)

FAMILY HISTORY

Please check off any **Conditions** that apply to **YOUR FAMILY:**

☐ Arthritis ☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Heart ☐ Kidney ☐ Thyroid

☐ Other:

☐ Cataracts ☐ Glaucoma ☐ Blindness ☐ Crossed/Lazy Eye ☐ Retinal Disease ☐ Macular Degeneration

☐ Other:

INSURANCE SIGNATURE ON FILE

I certify that the information given by me in applying for vision/medical insurance is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and I authorize payment of these benefits directly to the doctor on my behalf for any services furnished. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services.

I understand I am responsible for the balance of fees not paid by my insurance.

Patient Signature (Patient's Legal Representative) **Date** / /

HIPAA PRIVACY ACKNOWLEDGMENT OF RECEIPT OF NOTICE PRIVACY PRACTICES

I, _____ [please print full legal name] (the "Patient" or "Patient's legal representative"), have been presented with the Notice of Privacy Policy (the "Policy") of Clearpoint Vision (the "Provider"), and have been offered a copy of such policy to keep for my records.

_____ [Please initial] I hereby acknowledge that I have been provided with a copy of the Policy.

_____ [Please initial] I hereby refuse to acknowledge receipt of the Policy. I understand that even though I may refuse to sign this acknowledgement, Provider may still provide treatment to me.

Patient Signature or Patient's Legal Representative **Date** / /

AT CLEARPOINT VISION, WE PRIDE OURSELVES ON PROVIDING OUR PATIENTS WITH THE BEST POSSIBLE STANDARD OF CARE. WE ARE COMMITED TO EARLY DETECTION AND PREVENTION OF EYE DISEASES. WE STRONGLY RECOMMEND THAT ALL OF OUR PATIENTS RECEIVE ALL THESE TESTS AS PART OF THEIR COMPREHENSIVE VISUAL ANALYSIS ONCE PER YEAR.

AN OPTOMAP RETINAL SCAN provides the doctor with a view of approximately 82% of your retina in a single capture. Retinal problems such as macular degeneration, glaucoma, retinal holes, retinal detachments and diabetic retinopathy can now be seen without dilation for most patients. There are no side effects. Early detection is crucial!

The fee is only $39.00 (it is usually not covered by vision insurance).

A VISUAL FIELD ANALYZER is a highly computerized instrument that provides us a more thorough analysis of your field of vision. **VISUAL FIELD SCREENING** can assist us in early detection of glaucoma, retinal problems, some neurological diseases and may diagnose causes of headaches.

If not covered by your plan, there is a $20.00 fee for the visual field screening.

☐ **YES. I WANT THE VISUAL FIELD SCREENING** ☐ I would like to discuss it with the Doctor

I understand that without these tests, certain eye diseases and conditions may not be discovered. I agree to assume all risk associated with refusing these tests, indemnify, hold harmless, and release Clearpoint Vision, its employees and optometrists, from any and all claims or liability whatsoever related to failure to diagnose and/or treat any eye conditions due to lack of diagnostic information which could have been obtained by these tests.

OFFICE POLICY

All Visits to the office are due and payable at the time of service.

Fees paid for any services are NON-REFUNDABLE.

There will be no fee for follow up visits on glasses or contact lens fitting within 90 days of the initial comprehensive exam. Any follow ups on glasses or contact lens past 90 days the usual customary

	/ /
Patient Signature or Patient's Legal Representative	**Date**