

WELCOME BACK TO OUR OFFICE

Dr. Heloi Stark, O.D., P.C., Visual Image, 3900 Jermantown Rd., Suite 170, Fairfax, VA 22030, ph: 703.385.6134

Date: _____ Age: _____
Mr. Mrs. Ms. (Last name) _____ (First name) _____

PLEASE NOTIFY FRONT DESK OF ANY ADDRESS CHANGE

Home Tel:(_____) _____ - _____ Work Tel:(_____) _____ - _____ Cell phone:(_____) _____ - _____

Please star the phone number above where you would prefer to be contacted.

REASON FOR YOUR VISIT TODAY (PLEASE CHECK ALL THAT APPLY)

- | | | |
|--|--|---|
| <input type="checkbox"/> Routine eye exam | <input type="checkbox"/> Contact lens examination | <input type="checkbox"/> Laser vision consultation |
| <input type="checkbox"/> Blurred distance vision | <input type="checkbox"/> Sees spots, floaters | <input type="checkbox"/> Eyes itch, water or burn |
| <input type="checkbox"/> Blurred near vision | <input type="checkbox"/> Sees flashes of light | <input type="checkbox"/> Eye pain, pressure or discomfort |
| <input type="checkbox"/> Blurred computer | <input type="checkbox"/> Pink eye/ conjunctivitis | <input type="checkbox"/> Frequent headaches |

Other: _____

HEALTH HISTORY (Please complete the boxed area below)

<p>Do you have any seasonal allergies? Yes / No If yes, please list: _____</p> <p>Do you have any allergies to medications? Yes / None known If yes, please list: _____</p> <p>Do you currently take any over the counter or prescription medications? Yes / No If yes, please list all medications: _____</p>

Please mark all options that apply to yourself or any member of your immediate family (siblings, parents, grandparents).

*****PLEASE USE THESE ABBREVIATIONS FOR BELOW: S (self) F (family) N (none)*****

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Amblyopia/ Lazy Eye | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Asthma/Lung | <input type="checkbox"/> Cancer or tumors |
| <input type="checkbox"/> Blindness | <input type="checkbox"/> Cardiovascular/heart | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> High cholesterol |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Ear/Nose/Throat | <input type="checkbox"/> Endocrine/ glands |
| <input type="checkbox"/> Eye injury | <input type="checkbox"/> Gastrointestinal | <input type="checkbox"/> Genitourinary | <input type="checkbox"/> Blood/Lymph/HIV exposure |
| <input type="checkbox"/> Eye surgery | <input type="checkbox"/> Mental | <input type="checkbox"/> Musculoskeletal | <input type="checkbox"/> Nervous system |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Skin disorders | <input type="checkbox"/> Thyroid disorder | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Retinal Detachment | Have you ever had any surgeries? _____ | | |
| <input type="checkbox"/> Macular Degeneration | Other eye conditions? _____ | | |

Do you use cigarettes/tobacco? Y/N Alcohol? Y/N Other substances? Y/N

Are you **pregnant**? Y/N If yes, how many weeks? _____ Are you lactating/ nursing? Y/N **Please notify Doctor if pregnant**

PAYMENT IS EXPECTED AS SERVICES ARE RENDERED

How will you be paying for today's visit? Cash Check MasterCard Visa American Express Discover

I clearly understand that it is my responsibility to know if I have vision insurance coverage AT THE TIME of my exam. I authorize the use of this form on all of my insurance submissions. I authorize release of information to all of my insurance companies. I authorize payment directly to my doctor. I permit a copy of this authorization to be used in place of the original. I understand I am responsible for my complete bill and balance due. If insurance coverage cannot be verified on the day of service, I understand that I will be responsible for submitting my own claims. No information about my case will be released to or discussed with an outside party without my written request authorizing the release (HIPAA).

Please note: Polycarbonate lenses for eyeglasses are ten times more impact resistant than plastic lenses.

Patient signature: _____

(Please have parent or guardian sign this form if patient is a minor)

06-09-03

PLEASE COMPLETE REVERSE SIDE

PUPILLARY DILATION

A pupillary **dilation** is the most thorough comprehensive eye examination, and should be assessed **annually** in order to maintain the proper health of the structures inside the eye including the optic nerve, retina and macula. Dilation enables the optometrist to more easily identify cataracts, macular degeneration, tumors, bleeding, and many other vision threatening problems. Dilation is indicated in **trauma, diabetes, hypertension, headaches, high spectacle prescriptions, and for patients who are seeing flashing lights or floating spots.** **Dilation is like a full physical for your eyes, and is recommended for all of our patients, especially new patients and children.**

The process involves the use of **eye drops** to dilate the pupils and the patient is instructed to wait approximately twenty to thirty minutes for adequate dilation to occur. Distance vision may be blurred and near vision will be blurred for about 4-6 hours as the dilation gradually wears off. There will also be some light sensitivity for which the front desk will supply you with a pair of complimentary disposable sunglasses. Some patients feel uncomfortable with driving after being dilated, and wish to return to our office with a designated driver at a later visit. There is an **additional fee of \$20.00 to cover the extra time spent for this procedure.** Fee may vary based on insurance.

Yes, I want my eyes dilated at this time. **(\$20.00)** **Yes**, I want my eyes dilated at a later time. **(\$35.00)**

No, I do not want my eyes dilated at this time despite the **annual** recommendation by the optometrist.

Signature _____ Date _____

VISUAL FIELD SCREENING

In an effort to provide total vision care to our patients, we are now offering our new automated visual field screening in combination with your annual comprehensive vision examination. This is a state of the art test performed to rule out the early signs of ocular disease. This test involves the use of a special **computer to evaluate both your central and peripheral vision, and is used to detect eye diseases such as glaucoma, macular degeneration, tumors of the eye and brain, and visual changes secondary to diabetes and hypertension.** **We strongly recommend that all of our patients over the age of six receive the screening version of this exam.** It is especially important for patients who have frequent headaches, circulatory problems, and borderline eye pressures. There is an **additional charge of \$15.00 for the visual field screening.**

Yes, I do want the visual field screening at this time.

No, I do not want the visual field screening at this time.

Signature _____ Date _____

*****Please note: Polycarbonate lenses for eyeglasses are ten times more impact resistant than standard plastic lenses (CR-39). Dress wear frames are not for safety use or sports, injury or loss of vision could occur.***** Initials

Please read and complete below ONLY if this is an exam for CONTACT LENSES

As with any drug or device, the use of contact lenses is not without risk. A small, but significant, percentage of individuals wearing contact lenses could develop potentially serious complications that can lead to permanent eye damage. **If you have any unexplained eye pain or redness, watering of the eye or discharge, cloudy or foggy vision, recent onset decrease in vision, or increased sensitivity to light, immediately REMOVE YOUR CONTACT LENSES AND MAKE ARRANGEMENTS TO SEE YOUR EYE CARE PROFESSIONAL BEFORE WEARING YOUR CONTACT LENSES AGAIN.** Contact lenses should never be worn during sleeping hours due to the increased risks for infections and ulcers with overnight wear. Also, contact lenses should never be worn when you are in or around any fresh or salt water, including showers, hot tubs, swimming pools or the beach (serious eye infections and or loss of vision could occur).

It is of utmost importance that you return to your prescribing doctor for ALL FOLLOW-UP CARE. A one-week follow-up is required to finalize the contact lens prescription, and a contact lens prescription once finalized is valid for one year after the exam date. The contact lens examination fee includes up to three routine follow-ups at no charge during the first six weeks after the examination. Contact lenses should be evaluated on your eyes every six months, and a comprehensive contact lens examination should be completed every year.

By my signature, I acknowledge that I will comply with the recommended care and follow-up instructions.

(patient, or legal guardian if minor)

Date