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):_____

Street Address: _____ City: _____ State: _____ Zip Code: _____

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

Email Address: _____

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

Vision Insurance: _____ Member ID#_____ Employer: _____

Medical Insurance: _____ Member ID#_____ Employer: _____

Primary Care Physician: _____ PCP P: (____)_____-_____ PCP F: (_____)_____-_____

REASON FOR YOUR VISIT TODAY (Please check ALL that apply)

___ Routine Eye Exam
___ Blurred Distance Vision
___ Blurred Near Vision
___ Blurred Computer
___ Contact Lens Examination
___ Sees Spots, Floaters
___ Sees Flashes of Light
___ Pink eye/Conjunctivitis
___ Laser Vision Consultation
___ Eyes itch, water, or burn
___ Eye Pain, Pressure, or Discomfort
___ Frequent Headaches

Other: _____

HEALTH HISTORY

Do you have any seasonal allergies? Yes / No If yes, please list: _____

Do you have any **allergies to medications**? Yes / None Known If yes, please list: _____

Do you currently take any over the counter or prescription medications? Yes / No If yes, please list all medications:

_____

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

Please circle S (Self) F (Family) **& Indicate Family Member** or Leave Blank for N/A

Or, If no medical history has changed, Circle: No Change

S / F Amblyopia/Lazy Eye
S / F Blindness
S / F Cataracts
S / F Eye Injury
S / F Eye Surgery
S / F **Glaucoma**
S / F Retinal Detachment
S/ F **Macular Degeneration**

S / F Arthritis
S / F Cardiovascular/Heart
S / F Nervous System
S / F Gastrointestinal
S / F Mental
S / F Skin Disorders
S / F Asthma/Long
S / F **High Blood Pressure**

S / F Ear/Nose/Throat
S / F Genitourinary
S / F Musculoskeletal
S / F Thyroid Disorder
S / F Cancer or Tumors
S / F High Cholesterol
S / F Endocrine/Glands
S / F Blood/Lymph/HIV

S / F Diabetes
If Diabetic Last A1C:_____
S/F Other:_____
Any Surgeries?: _____
_____
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

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 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 (HIPPA).

Patient Signature: _____ (Please have parent or guardian sign this form if patient is a minor)

PUPILLARY DILATION

A pupillary dilation is the most thorough comprehensive eye examination, and should be assessed annually in order to maintain proper health of the structure 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.

___ **Yes**, I want my eyes dilated at this time. (no charge) ___ **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 $20.00 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. **Please Initial _____**

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 increased risk 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). Also do not wear contact lenses while sick or while flying.**

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 the fitting/re-evaluation and up to two 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.

Signature: _____ Date: _____

(patient, or legal guardian if minor)