Madeira Optical

Patient Information

(Please Print)

PATIENT INFORMATION

Patient's Last Name	First	Middle	☐ Mr. ☐ Miss ☐ Mrs. ☐ Dr.	Today's Date / /
Street Address	City	State Zip	Social Security #	Phone Numbers H:
E-mail Address:				M:

Employer	Occupation or School Grade	Date of Birth / /	Age	Gender ☐ M ☐ F

How may we contact you? (You can change any time)

☐ Email (Primary Recall Method) ☐ Home Phone ☐ Mobile Phone ☐ Text Message

Please let us know how you heard about us:

INSURANCE INFORMATION *PLEASE PRESENT INSURANCE CARD AT THE RECEPTION DESK*

Primary Insured's Name	Insured's Social Security #	Insured's DOB	Policy #	Insurance Company

Patient's Relationship to Insured	☐ Self	☐ Spouse	☐ Child	☐ Other
Patient's Marital Status	☐ Single	☐ Married	☐ Other	
Patient's Employment Status	☐ Employed	☐ Student	☐ Part-time Student	☐ Other

VISUAL COMFORT *PLEASE CHECK ALL THAT APPLY*

☐ Light Sensitivity	☐ Artificial Light Sensitivity	☐ Difficulty Seeing at Night	☐ Eye Strain	☐ Glare

CURRENT EYEWEAR INFORMATION

I Currently Wear Eyeglasses	☐ Yes	☐ No
How Old Are Your Eyeglass Lenses?	☐ Main/Dress_____ Years	☐ Back-up_____ Years
I Currently Wear Rx Sunglasses	☐ Yes	☐ No
I Currently Wear Contact Lenses	☐ Yes, Soft Contact Lenses/Disposable	☐ Yes, Rigid Gas Permeable
My Current Contacts are Comfortable	☐ Yes	☐ No
I am Interested in Trying Contacts	☐ Yes	☐ No

VISUAL DEMANDS *PLEASE LIST ALL ACTIVITIES THAT APPLY & DAILY TIME*

☐ Computer/Tablet/Phone _____ Hours	☐ Sports Activities	☐ Outdoor Activities
☐ Reading/E-readers _____ Hours	☐ Occupational Driving _____ Hours	☐ Work/Recreational Safety

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I have read and understand the privacy policy I signed on my first visit. I understand that this policy is available for review. I understand that I am financially responsible for any balance. I authorize Madeira Optical and my insurance company to release any information required to process my claims.

PATIENT / GUARDIAN SIGNATURE	PRINTED GUARDIAN NAME (if applicable)	DATE

Medical History Questionnaire

Name:	Date:	Last Eye Exam:
Do you have allergies to medication? **Y/N**	If yes, please explain:	

Please list medications you take, including over the counter medications, oral contraceptives, aspirin, and home remedies:

List all major surgeries and/or hospitalizations you have had:

FAMILY HISTORY *Please note any family history (living or deceased grandparents, parents, siblings, and children)*

CONDITION/DISEASE	SELF	FAMILY HISTORY	RELATIONSHIP TO YOU
Blindness	☐	☐	
Cataract	☐	☐	
Crossed Eyes	☐	☐	
Glaucoma	☐	☐	
Macular Degeneration	☐	☐	
Retinal Detachment	☐	☐	
Diabetes	☐	☐	
Heart Disease	☐	☐	
High Blood Pressure	☐	☐	
Thyroid Disease	☐	☐	
Other	☐	☐	

SOCIAL HISTORY *(This information is kept confidential. However, you may discuss this portion directly with the doctor if you prefer.)*

☐ Yes, I would like to discuss my social history with my doctor. (check box)

	NO	YES		NO	YES
Are you pregnant or nursing?	☐	☐	Do you drink alcohol?	☐	☐
Do you use tobacco products?	☐	☐	Do you take illegal drugs?	☐	☐

Have you ever been exposed to or infected with: ☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis

REVIEW OF SYSTEMS *(Please list any previous or current problems below)*

	NO	YES	?
CONSTITUTIONAL			
Fever, Weight loss/Gain	☐	☐	☐
INTEGUMENTARY (Skin)	☐	☐	☐
NEUROLOGICAL			
Headaches	☐	☐	☐
Migraines	☐	☐	☐
Seizures	☐	☐	☐
EYES			
Loss of Vision	☐	☐	☐
Blurred Vision	☐	☐	☐
Loss of Side Vision	☐	☐	☐
Double Vision	☐	☐	☐
Dryness	☐	☐	☐
Mucous Discharge	☐	☐	☐
Redness	☐	☐	☐
Sandy or Gritty Feeling	☐	☐	☐
Itching	☐	☐	☐
Burning	☐	☐	☐
Foreign Body Sensation	☐	☐	☐
Excess Tearing/ Watering	☐	☐	☐
Glare Sensitivity	☐	☐	☐
Eye Pain or Soreness	☐	☐	☐
Chronic Infection of Eye/Lid	☐	☐	☐
Eyestrain	☐	☐	☐
Styes or Chalazion	☐	☐	☐
Flashes in Vision	☐	☐	☐
Floaters in Vision	☐	☐	☐
Distorted Vision	☐	☐	☐
PSYCHIATRIC	☐	☐	☐

	NO	YES	?
ENDOCRINE			
Thyroid/Other Glands	☐	☐	☐
EAR, NOSE & THROAT			
Allergies/Hay Fever	☐	☐	☐
Sinus Congestion	☐	☐	☐
Chronic Cough	☐	☐	☐
Dry Throat/Mouth	☐	☐	☐
RESPIRATORY			
Asthma	☐	☐	☐
Chronic Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
VASCULAR/CARDIOVASCULAR			
Diabetes	☐	☐	☐
Heart Pain	☐	☐	☐
High Blood Pressure	☐	☐	☐
Vascular Disease	☐	☐	☐
GASTROINTESTINAL			
Diarrhea	☐	☐	☐
Constipation	☐	☐	☐
GENITOURINARY			
Genitals/Kidneys/Bladder	☐	☐	☐
BONES, JOINTS, MUSCLES			
Rheumatoid Arthritis	☐	☐	☐
Muscle Pain	☐	☐	☐
Joint Pain	☐	☐	☐
LYMPHATIC/HEMATOLOGIC			
Anemia	☐	☐	☐
Bleeding Issues	☐	☐	☐
ALLERGIC/IMMUNOLOGIC	☐	☐	☐

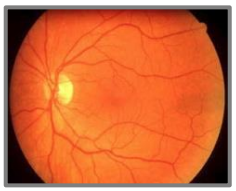
If you answered YES to any of the above or have a condition not listed, please explain & list medication:

Dr. Malinda Pence & Assoc., Inc.

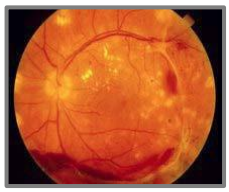
(1) Digital Retinal Image Screening

As part of your eye exam, we recommend a valuable diagnostic called Digital Retinal Image Screening. The doctor is concerned about retinal problems including Macular Degeneration and Glaucoma, as well as systemic diseases such as Diabetes, Stroke and High Blood Pressure. These conditions can lead to partial vision loss or blindness, and often can develop without warning and can progress without symptoms. Your digital image screening provides:

- High resolution baseline images of your retina, macula, optic nerve and blood vessels.
- A permanent record that is very valuable in assessing the health of your eyes and tracking any year over year changes in your eyes.
- The ability to view your digital image during your examination.



Healthy Eye



Diseased Eye

Retinal Image Screening is painless and is comparable to taking an annual baseline dental x-ray. Retinal images are especially important for those who have a personal or family history of ***Glaucoma, Diabetes, High Blood Pressure, Retinal problems or a high prescription.*** In addition to annual screenings, doctors may order medical retinal images as a component of the diagnosis and treatment of eye diseases, which may be covered by insurance.

The professional fee is **$25** for screening images of both eyes due at the time of service. Most managed care plans do not cover this advanced screening option. Ask your doctors for details.

_____**YES**, I ELECT baseline a retinal screening and digital images added to my medical records.

_____**NO**, I DECLINE retinal image screening. The doctor may request images as part of a medical diagnosis.

(2) Patient Consent for Use & Disclosure of Protected Health Information

I hereby give my consent for Dr. Malinda Pence & Assoc., Inc. to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Dr. Malinda Pence & Assoc., Inc. Notice of Privacy Practices available at the office describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Dr. Malinda Pence & Assoc., Inc. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Dr. Malinda Pence & Assoc., Inc.

With this consent, Dr. Malinda Pence & Assoc., may contact my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Dr. Malinda Pence & Assoc., Inc. may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With this consent, Dr. Malinda Pence & Assoc., Inc. may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Dr. Malinda Pence & Assoc., Inc. restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Dr. Malinda Pence & Assoc. to use and disclose my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Dr. Malinda Pence & Assoc., Inc. may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Print Patient Name (And Legal Guardian Name if Applicable)

Date