Name_____ **DOB**_____ **Date**_____ **Dr**_____

ID: Old_____ New_____ **New:** YES NO **Email:** _____

Pt: Photo_____ ID_____ Health Hx_____ INS_____

RX: OD_____ OS_____ ADD_____

Visit Type: EXAM CLFIT CLFU OTHER_____ EMERGENCY_____

POM CAT_____ POM YAG_____ DR_____

Testing: IOP_____ Auto Ref_____ Optos: N Y- Reg Med OCT_____ Fields_____

Doctor's Notes: Recall: _____ **Macuhealth:**_____

(VSP) Diabetes____ Diabetic Retin____ Hypertension____ High Cholesterol____ Dilation____

CL fitting: 25_____ 35_____ 45_____ 90_____ Other_____

Lens Recommendations: Poly BL AR TR Polar Other:

We pride ourselves on providing our patients with the best possible standard of care. Because of this, we now perform an Optomap Retinal screening. This is the newest and most advanced technology to create and maintain a photo record of your retinal health. Yearly scans enable the doctor to make important comparisons necessary for the early diagnosis of retinal conditions or diseases. Our doctors strongly believe that the screening is an essential part of your comprehensive eye exam. **Because this screening is not covered under a routine diagnosis there will be a $10.00 co-pay to you.** Those who are 22 and under will not be charged. If there is an active qualifying medical condition, additional images may be taken. Additional images may be covered under a medical insurance plan. If so, your medical co-pays/ deductibles would apply.
This screening is recommended by your doctor, however it is your choice. Please initial below:

_____**YES I agree to the above charges and would like the Optomap Retinal Screening today.**

_____ **NO I wish not to have the Optomap Retinal Screening today and will not be charged for it.**

PLEASE READ CAREFULLY, THEN SIGN & DATE: I, the undersigned, assign directly to this office all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges not paid by insurance. I understand that if any unpaid balance is assigned to a collection agency or attorney, I will be responsible for a collection fee of 33.3% added to my account. I hereby authorize the doctor to release all information to secure the payment of benefits. I authorize the use of this on all insurance submissions. I understand that visiting this facility could result in contraction of COVID-19 and I will not hold Professional Eyecare Associates responsible should this occur. I have also been notified of the Notice of Privacy Practices from Professional Eyecare Associates.

* _____ * _____

Responsible Party **Date**

Professional EyeCare Associates
Dr. Niemeier , Dr. Hussmann

PATIENT HEALTH HISTORY FORM

Last Name:	**First Name:**	**Middle Initial:**	**Date of Birth:**	
Height:	**Weight:**	**Smoker:** Y or N	**Language:** English or Specify Other _____	
Race: *(Circle One)*	African-American	American-Indian	Asian	Native-Hawaiian	Caucasian	Other
Employment: *(Circle One)*	Retired	Employed	Full-Time Student	Part-Time Student	Other	
Marital Status: *(Circle One)*	Single	Married	Divorced	Widowed	Other	
Primary Care Physician:	**Last Eye Exam:**	**Blood Pressure:**		

FAMILY HEALTH HISTORY

Glaucoma	Y	N	Diabetes	Y	N	Macular Degeneration	Y	N
Cataract	Y	N	Hypertension	Y	N	Other: _____		

SELF HEALTH HISTORY

Glaucoma	Y	N	Heart Disease	Y	N
Cataract	Y	N	Stroke	Y	N
Macular Degeneration	Y	N	Vascular Disease	Y	N
Diabetes	Y	N	Cholesterol	Y	N
Hypertension	Y	N	Multiple Sclerosis	Y	N
Cancer	Y	N	Epilepsy	Y	N
Drug Allergy	Y	N	Alzheimer's	Y	N
Environmental Allergy	Y	N	Parkinson's	Y	N
Rheumatoid Arthritis	Y	N	Cerebrovascular	Y	N
Lupus	Y	N			
			STD/STI	Y	N
Fibromyalgia	Y	N	Viral Herpetic	Y	N
Muscular Dystrophy	Y	N	Chlyamydia	Y	N
Osteoarthritis	Y	N			
Ankylosing Spondylitis	Y	N	Anemia	Y	N
			Large Volume Blood Loss	Y	N
Crohn's	Y	N	Leukemia	Y	N
Colitis	Y	N	Asthma	Y	N
Ulcer	Y	N	Bronchitis	Y	N
Digestive	Y	N	Emphysema	Y	N
Developmental Disability	Y	N	Non-Insulin Dependent Diabetes	Y	N
Weight Loss	Y	N	Insulin Dependent Diabetes	Y	N
Fever	Y	N	Thyroid Dysfunction	Y	N
Fatigue	Y	N	Hormonal Dysfunction	Y	N
Trauma	Y	N			
Depression	Y	N			
Panic Disorder	Y	N			
Schizophrenia	Y	N			
Inflammatory Disorders	Y	N			
Blurred Vision	Y	N			
Double Vision	Y	N			
Eczema	Y	N			
Rosacea	Y	N			
Psoriasis	Y	N			

List Surgeries:

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List Medications:

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List Medicine Allergies:

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