CUSTOM EYES

EYE EXAMS • FRAMES • CONTACT LENSES

1871 2nd St Springfield OR 97477 Pam Ebert OD, LLC PH(541)741-0122 Fax (541)988-3401

Patient Intake Form Date_____

Last Name_____First_____MI_____DOB_____

Address_____Home #_____Cell_____

City_____State_____Zip_____SS#_____

Date of Last Eye Exam_____Emergency Contact Name/ #_____

Guardian_____Occupation_____Referred By_____

Email address_____Preferred contact (circle) home phone/ cell/ email / text

Personal Eye Information

Reason for Visit □Routine Glasses exam □Routine Contact Lens exam □ Medical exam

Do you have any of the following (circle any that apply or □check here if none apply)

Blurred distance vision Blurred near vision Double vision Crossed eyes Dry eyes Red eyes Glaucoma Cataracts Macular Degeneration Retinal Detachment Diabetic Retinopathy

Do you have other eye conditions or problems? Yes/ no Describe_____

Have you had any eye surgery or injury yes/ no Describe_____

Do you wear glasses? yes/ no Contact lenses? Yes/no what type_____

General Medical Information

Name of medical Dr_____Date of last physical exam_____

Phone #_____Pregnant ? yes / no

Allergies to medications?Yes/no _____

Problems with any of these systems?

Ear/ Nose/ throat yes/ no	Cardiovascular yes/ no	Pulmonary yes/ no
Urinary yes/ no	Gastrointestinal yes/ no	Endocrine yes/ no
Muscle/ bones yes/ no	Skin yes/ no	Neurological yes/ no
Psychiatric yes/ no	Blood/ lymphatic yes/ no	Immune yes/ no

Please explain any yes answers_____

Diabetes yes/ no Type_____Duration_____ Last blood sugar_____ Last A1C_____

Other health problems?_____

Current Medication(s)(□check if none)_____

Major Surgeries & Hospitalizations_____

Do you use tobacco? yes/ no Do you drink alcohol? Yes/ no Do you use illicit drugs? Yes/ no

Family History

(parents, grandparents, or siblings)

Cataracts yes/ no relation_____ Heart disease yes/ no relation_____

Glaucoma yes/ no relation_____Diabetes yes/ no relation_____

Macular Degeneration yes/ no relation_____Cancer yes/ no relation_____

Retinal Detachment yes/ no relation_____Hypertension yes/ no relation_____

Dilation Information

It is our goal to provide a thorough comprehensive eye examination. To effectively accomplish examining your retina, it is important to dilate the pupils of your eyes. This will require placing drops in your eyes. As with many medications, there are some side effects of the drops which are used. These side effects include light sensitivity and blurred near vision.In MOST, but not all cases, the distance vision is not affected.The side effects last about 6 hours, but can last as long as 24 hours. While we believe that a dilated retinal exam is an important part of the eye exam, we do give you the option to decline this procedure.

Please indicate your preference below:

□ I wish to be dilated today , am aware of the side effects of the drops and agree to hold Pam Ebert OD harmless as a result of my decision _____signature

□ I do not wish to be dilated today and agree to hold Pam Ebert, OD harmless as a result of my decision. I also acknowledge that my retinas will not be fully examined. _____signature

HIPPA Compliance Acknowledgement of Receipt

I acknowledge that I was offered or received a copy of Pam Ebert, OD's Notice of Privacy Practices

Patient, Parent or Guardian Signature_____

Insurance Information

Vision Insurance_____Group #_____

ID #_____Name of Insured_____DOB_____

Medical Insurance_____Group #_____

ID #_____Name of Insured_____DOB_____

I certify that the information given by me in applying for insurance/ medicare payment is true and correct. If I have not provided insurance information, I forfeit the right to have insurance benefits filed for me. I authorize my doctor to act as my agent in helping me to obtain payment of my insurance and/ or medicare benefits, and I authorize payment of these benefits to Pam Ebert, OD on my behalf for any services and materials furnished. I authorize any holder of medical information about me to release to the Health Care Administration and it's agents any information needed to determine these benefits payable to related services. I also understand that if my insurance company does not provide payment to Pam Ebert, OD, I will be held reponsible for said services and materials, as well as any legal and or collection fees required to collect such payment.

Patient, Parent, or Guardian signature_____date_____