



EYE GALLERY

DOCTORS OF OPTOMETRY

Colorado Vision Specialists P.C.
Doctors of Optometry

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Thank you for trusting us to keep your eyes healthy!

New Patient Previous Patient

Last Name _____ First Name _____ DOB _____ / _____ / _____
mo day year

Address _____
Street Address City State Zip Code

Best Phone # _____ Employer _____ Occupation _____

Hobbies and Activities _____ Location of last eye exam _____ Year _____

E-mail _____

Your reasons for visiting our office today:

Please check any that apply.

- | | | | | |
|---|--|--|--|-------------------------------------|
| <input type="checkbox"/> Routine Eye Examination | <input type="checkbox"/> Distance blur | <input type="checkbox"/> Near vision changes | <input type="checkbox"/> Eyes itch | <input type="checkbox"/> Eyes burn |
| <input type="checkbox"/> Interested in new glasses | <input type="checkbox"/> Dry eyes | <input type="checkbox"/> Eye fatigue | <input type="checkbox"/> Eye pain | <input type="checkbox"/> Red eye(s) |
| <input type="checkbox"/> new contacts | <input type="checkbox"/> Glare | <input type="checkbox"/> Halos | <input type="checkbox"/> Flashes of light | <input type="checkbox"/> Floaters |
| <input type="checkbox"/> Glasses recently lost or broken | <input type="checkbox"/> Contact lens discomfort | | <input type="checkbox"/> Peripheral vision changes | |
| <input type="checkbox"/> Interested in trying contacts for the first time | <input type="checkbox"/> Computer use: _____ hours / day | | <input type="checkbox"/> _____ | |
| <input type="checkbox"/> Interested in Laser Vision Correction | | | | |

Please indicate if you or any blood relatives have the following conditions:

	<u>You</u>	<u>Relative</u>	<u>Who</u>		<u>You</u>	<u>Relative</u>	<u>Who</u>
Heart Disease	no yes	no yes	_____	Eye Injuries	no yes		
High Blood Pressure	no yes	no yes	_____	Eye Surgeries	no yes		
High Cholesterol	no yes	no yes	_____	Cataracts	no yes	no yes	_____
Thyroid	no yes	no yes	_____	Glaucoma	no yes	no yes	_____
Multiple Sclerosis	no yes	no yes	_____	Retinal Issues	no yes	no yes	_____
Migraines	no yes	no yes	_____	Lazy Eye	no yes	no yes	_____
Diabetes (select type below)	no yes	no yes	_____	Macular Degeneration	no yes	no yes	_____
Type I Type II				Other _____			

Do you have allergies to any medications? Yes No If yes, please describe _____

Are you currently pregnant or nursing? Yes No (discuss dilation alternatives with the doctor if you are pregnant or nursing)

Please list current medications (including pain relievers, birth control, vitamins and supplements) also list any **Eye Specific Medications** including over the counter items and/or drops.

Dilated Pupil Examination

Dilated pupil examination provides a more thorough eye health examination. Dilation allows the doctor to obtain a better view of the back of the eye. Retinal health, cataracts, glaucoma, and effects of systemic diseases such as diabetes or high blood pressure are more thoroughly evaluated with dilation. Drops are placed into the eye to enlarge the pupil. Temporary side effects include but are not limited to light sensitivity and blurred vision (primarily near vision). **These effects will diminish after 30 to 60 minutes, but may last 4 to 6 hours.** Evaluate your vision prior to driving and protect your eyes with sunglasses. Dilation is included in the comprehensive eye exam on the day of the exam if you choose this option.

- Yes**, I would like to have my **eyes dilated** today. I understand the side effects and the explanation above.
- No, I understand the risks and benefits and choose **not** to have my eyes dilated today. Dilation may be scheduled for another day.

Digital Retinal Imaging is NEW technology now offered as a supplement to dilation and the comprehensive eye exam.

Visual Field Screening

Yes, I would like to perform the **\$10 Visual Field Screening**. I understand there are **no lasting side effects**.

Insurance

Not using Insurance Vision Insurance: Primary Insured's Full Name _____

Eye Care Plan Name _____ Primary Date of Birth _____ Primary ID # or SSN _____

I authorize the use of my personal information to process insurance benefits. I request insurance benefits be made on my behalf to Colorado Vision Specialists P.C. for any services provided by Colorado Vision Specialists. I understand that I will be responsible for any services not completely covered by insurance or any services which I am determined to be ineligible. My health history is updated and I understand the all of the above.

Signature of Patient _____ **Date** _____

(or responsible party)