Patient Intake Form

Welcome To Our Office.
All information will be kept confidential.
Please print and complete all items fully.

☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Dr. SS# _______/_____/________ Today's date __________/________/__________

Last Name ___________________________________ First ____________________ MI ____ Gender ______ DOB _____/_____/______

Address____ Home Ph ( ) _________________ Cell Ph ( ) _________________

City __________________________________ State ____ Zip __________-_______ E-mail ____

Occupation ____ Employer____

Date of last eye exam ____________________ Were you dilated? Yes / No Referred by ____

Emergency contact name (s) ____ Phone number(s) ( ) _______________________________

Personal Eye Information

Reason(s) for visit: ☐Eye Exam ☐First time contact lens fitting ☐Update for current contact lenses ☐Refit contact lenses ☐Medical problem

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

Blurred Vision Glaucoma Cataracts Dry Eyes Macular Degeneration Retinal Detachment Flashes / Floaters

Do you have any other eye conditions or problems? Yes / No Describe ____

Have you had any eye injuries or surgeries? Yes / No Describe ____

Do you wear glasses? Yes / No Contact Lenses? Yes / No what type? ____

Additional information ____

General Medical Information

What is your general health? __________________ Date of last physical exam __________________ Date of last tetanus shot ________________

Name of family doctor ____ Phone # ( ) _______________________ Pregnant? Yes / No / N/A

Do you have problems with any of these systems? (Please circle yes or no)

Cardiovascular (Heart)	Yes / No	Urinary / Genital	Yes / No	Endocrine (glands)	Yes / No
High Blood Pressure	Yes / No	Muscles / Bones	Yes / No	Blood / Lymph	Yes / No
Ears / Nose / Throat	Yes / No	Integumentary (Skin)	Yes / No	Allergic / Immunologic	Yes / No
Respiratory (Lungs)	Yes / No	Nervous System	Yes / No	Headaches	Yes / No
Gastrointestinal	Yes / No	Psychiatric	Yes / No	Eyes	Yes / No

Please explain ____

Diabetes Yes / No Type _________________ Date of diagnosis _____________ Last blood sugar count ___________ Last A1C ____________
_

Allergies to medication? Yes / No Which? _____________________________________ Reactions? ___________________________________

Other health problems ____

Currents medication(s) (☐ check if none) ____

Have you had any eye surgeries? Yes / No Which? ____ When? _______________________

Additional information ____

Family History

High blood pressure Yes / No Relation ______________ Macular degeneration Yes / No Relation ______________

Diabetes Yes / No Relation ______________ Retinal detachment Yes / No Relation ______________

Glaucoma Yes / No Relation ______________ Cataracts Yes / No Relation _____________

Dilation Information

It is our goal to provide a complete and thorough comprehensive eye examination. To effectively accomplish our goal, we feel it is important to dilate the pupils of your eyes. This will require placing drops in your eye. As with many medications, there are some side effects of the drops used to dilate the pupil. These include sensitivity to light and blurred reading vision. In most cases, the distance vision will not be affected. The side effects usually last several hours but can, in some instances, last up to 24 hours.
While we believe that dilation is an important part of the eye examination process, we understand that you may wish to defer or decline this procedure. **Please indicate your preference below:**

☐ I wish to be dilated today.
☐ I do not wish to be dilated at this time but will return for this procedure at a later date (there is no additional charge when you return for routine dilation within 90 days from your examination date).
☐ I do not wish to be dilated and agree to hold Shettle Family Eye Care & Eye Wear*, P.A.* harmless as a result of my actions.

HIPPA Compliance Acknowledgement of Receipt

I acknowledge that I received a copy of D. Scott Shettle, O.D., P.A., Notice of Privacy Practices.

Allow access to all patient records and information to: (none or full name/relationship):___________________________________

Patient, Parent or Guardian Signature:____ **Date:** ______/______/_______

Financial Information

Payment for services is required at the time of service. Please indicate below how you intend to pay for your professional fees and/or materials not covered by any insurance. We accept the following forms of payment:

☐ Cash ☐ MasterCard/Visa ☐ American Express ☐ Discover ☐ Care Credit

If you are using insurance, please complete the following section:

Name of insurance ____

Primary insured's name ____ Relationship to patient _______________________

Policy # ______________________________ Group # _________________ Primary's DOB ________/_______/______

Lifetime Patient Signature (Your signature below is required to bill your insurance company). I request that payment of authorized Medicare, Medicaid, or other insurance benefits either to me or on my behalf be made to D. Scott Shettle, O.D., P.A. for any services furnished to me by the doctor. I authorize any holder of medical information about me to release to my insurance company or *Centers for Medicare and Medicaid Services* and its agent any information needed to determine these benefits or the benefits payable for related services. I also understand that if my insurance company does not provide payment to D. Scott Shettle, O.D., P.A. I will be held responsible for said service(s).

Patient, Parent or Guardian Signature: ____ **Date:** ______/______/_______