



# 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. (\_\_\_\_\_) \_\_\_\_\_ Work Ph. (\_\_\_\_\_) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ - \_\_\_\_\_ E-mail \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Date of last eye exam \_\_\_\_\_ Were you dilated? \_\_\_\_\_ 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? ( \_\_\_\_\_ 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?    Describe \_\_\_\_\_

Have you had any eye injuries or surgeries?    Describe \_\_\_\_\_

Do you wear glasses?    Contact Lenses?    What type? \_\_\_\_\_

Do you use a computer?    How many hours per day? \_\_\_\_\_ 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? \_\_\_\_\_

### Do you have problems with any of these systems? (Please choose 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    Type \_\_\_\_\_ Date of diagnosis \_\_\_\_\_ Last blood sugar count \_\_\_\_\_ Last A1C \_\_\_\_\_

Allergies to medication?    Which? \_\_\_\_\_ Reactions? \_\_\_\_\_

Other health problems \_\_\_\_\_

Currents medication(s) ( check if none) \_\_\_\_\_

Have you had any surgeries? Which? \_\_\_\_\_ When? \_\_\_\_\_

Additional information \_\_\_\_\_

**Family History**

High Blood Pressure	Relation _____	Macular Degeneration	Relation _____
Diabetes	Relation _____	Retinal Detachment	Relation _____
Glaucoma	Relation _____	Cataracts	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 D. Scott Shettle, O.D., 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:

**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:** \_\_\_\_/\_\_\_\_/\_\_\_\_