Welcome to Shields Eye Associates

(Please print the answers to all questions. Your information will remain confidential per HIPPA Policy) Please present **BOTH** health and vision insurance cards **BEFORE** your exam)

Name:_____Date of Birth_____Today's Date:_____
Address: _____City:_____St:_____ Zip_____
Home Phone:_____Work Phone:_____Cell:_____
Employer/Occupation:_____email:_____
Do you have vision insurance? ❑No ❑Yes If yes, Provider? _____Member ID#_____
Do you have health insurance? ❑No ❑Yes If yes, Provider?_____Member ID#_____
Primary Insured Name_____ Primary Insured Date of Birth_____
How did you learn about our practice?_____

Personal Eye History

Date of Last Eye Exam:_____ By Whom:_____
Reason for exam today_____Interested in Contacts? ❑No ❑Yes
Current Contact Lens Type/Brand:_____Powers(if known)_R_____
Age of current contacts:_____Solution Type:_____ _L_____
Do you currently wear glasses? ❑No ❑Yes If yes, when do you wear your glasses? ❑Full-Time ❑Reading/ Computer ❑Distance/Driving
Who is you family/primary doctor?_____

Personal Medical History (Many general medical conditions affect the eye and your vision)

Do you take any prescription or non-prescription medicines regularly? ❑ yes ❑ no If yes, please list all medicines:

_____

_____

Do you have any medication allergies: ❑ None known ❑ Penicillin ❑ Sulfa Drugs
❑ Other: (Please list) _____

Do you have problems with the following medical systems? (Please check all that apply in each box)

Constitutional ❑ **None** ❑ Weight loss ❑ Fatigue ❑ Trauma ❑ Fever ❑ Cancer ❑ Other _____	**Neurological** ❑ **None** ❑ Multiple sclerosis ❑ Epilepsy ❑ Other _____	**Gastrointestinal** ❑ **None** ❑ Crohn's disease ❑ Colitis ❑ Ulcer ❑ Digestive concern ❑ Other_____
Allergic/Immunologic ❑ **None** ❑ Drug allergy ❑ Environmental Allergy ❑ Rheumatoid Arthritis ❑ Lupus ❑ Other	**Endocrine** ❑ **None** ❑ Type 1 Diabetes ❑ Type 2 Diabetes ❑ Thyroid Dysfunction ❑ Hormonal Dysfunction	**Musculoskeletal** ❑ **None** ❑ Fibromyalgia ❑ Muscular dystrophy ❑ Osteoarthritis ❑ Other _____
Cardiovascular ❑ **None** ❑ Heart disease ❑ Stroke ❑ Vascular disease ❑ High Blood Pressure/HTN ❑ High cholesterol	**Blood/Lymphatic** ❑ **None** ❑ Anemia ❑ Leukemia ❑ Other _____	**Integumentary / Skin** ❑ **None** ❑ Eczema ❑ Rosacea ❑ Psoriasis ❑ Other _____
Genitourinary ❑ **None** ❑ Urinary tract infections ❑ Kidney concerns ❑ STD: Herpes, Chlamydia, HIV ❑Other_____	**Psychiatric** ❑ **None** ❑ Depression ❑ Panic Disorder ❑ Schizophrenia ❑ Other_____	**Respiratory** ❑ **None** ❑ Asthma ❑ Bronchitis ❑ Emphysema ❑ Other_____
Ears, Nose & Throat ❑ **None** ❑ Upper respiratory tract infection ❑ Other_____	**Eyes** ❑ **None** ❑ Eye Irritation/Infection ❑Burning ❑ Floaters ❑Flashes ❑Blurred Vision ❑ Itching ❑Glare ❑Double Vision ❑Eye Pain ❑Tearing ❑ Dry Eye	❑Headaches ❑Migraines ❑Eye Injury ❑Eye Surgery ❑Lasik/PRK ❑Other_____

❑ Please check this box if you Do Not have any medical conditions. ❑Previous Patient No Changes

Family Medical History

Is there any family medical history of any of the following? (If yes, please list their relationship to you)

❑ None		❑ Corneal disease	_____
❑ Blindness	_____	❑ Lazy Eye	_____
❑ Cataracts	_____	❑ Diabetes	_____
❑ Glaucoma	_____	❑ Heart Disease	_____
❑ Macular Degen.	_____	❑ High Blood Pressure	_____
❑ Retinal Disease	_____	❑ Cancer	_____

Social History

Use tobacco? ❑ Yes ❑ No **Consume Alcoholic Beverages?** ❑ Yes ❑ No **Recreational Drugs** ❑ Yes ❑ No
Are you pregnant? ❑ Yes ❑ No **Nursing?** ❑ Yes ❑ No

CONTINUED ON BACK⇨

Insurance Information Release

When making a third party (Insurance) claim, I authorize the release of my medical information to process my third party claim. I authorize Shields Eye Associates, LLC/ Sharika Shields-Davis, O.D. to file complaints on my behalf if my third party carrier does not properly handle my claim. I authorize the release of any information pertinent to my case to any third party, adjuster or attorney involved in resolving the financial status of my account. I authorize my third party plan to pay Shields Eye Associates LLC/ Sharika Shields-Davis, O.D. directly. If my plan does not pay this claim, I understand that I am responsible for the payment of these professional services.

Signature_____ **Date**_____

_____ Doctor's Initials

_____/_____/_____ Date

Acknowledgment of Privacy and Voluntary Consent Form

In providing services to you, we create, receive, and store health information that identifies you. It is often necessary to use and disclose this information in order to treat you and conduct healthcare operations involving our office. The *Notice of Privacy Practices* posted in our office describes these uses and disclosures in detail. Please refer to this notice any time prior to signing this Consent Form. Copies are available for your personal documents.

I have read this Receipt and Consent Form and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment and healthcare options.

_____

Signature

If you are signing as a personal representative of the patient, please indicate your relationship to the patient and print your name.

Relationship to patient **Print Name**

_____ _____

Comprehensive Wellness Screening

Since our office is committed to the prevention of eye disease, as well as having you see your best, we recommend a painless Eye Wellness Screening. This offers the most technologically advanced disease screening in eyecare today! We offer a comprehensive retinal scan that provides a detailed internal scan of all layers of the retina to provide early detection of numerous eye diseases including Glaucoma, Macular Degeneration, Diabetes, Hypertension and More! This screening also includes a detailed peripheral visual field screening which helps to detect neurological ocular disease and glaucoma detection that can prevent vision loss. In addition, this screening includes pupil dilation if necessary; which allows the doctor to check the far corners of the eye for normally undetectable holes, tears, and detachments of the retina as well as other eye diseases.

This comprehensive screening **is strongly recommended for the following reasons**: (Please Check all that apply)

____ Diabetes
____ High Blood Pressure
____ Headaches or Migraines
____ New Floaters or Flashes of Light in Vision
____ Strong Glasses Prescriptions (Refractive Error > + or – 4.00 Diopters)
____ Family History of Glaucoma, Retinal disease, or other eye disease
____ Eye Pain
____ First exam at this office
____ Over the age of 40
____ Not had an eye exam in the past 2 years

While dilation is not necessary to perform this screening it is recommended by the doctor. The dilation process takes an additional 15 – 20 minutes. Some people may experience blurred vision up close and an increased sensitivity to light for up to 4 hrs. Driving is not usually impaired but requires extra attention.

There is an additional ***$49.00*** charge for this service and is **NOT** covered by most insurance plans.

Please Check One: ____Yes I wish to have the Wellness Screening Exam.
____ No, I do not wish to have this comprehensive exam to rule out eye disease.

Signature:X_____ Date:_____