4Sight iCare Patient Forms

PATIENT'S NAME: ____

-if a minor,
GUARDIAN'S NAME (& RELATION):____________________(__________)

To acknowledge that the "Notice of Privacy Practices" is available to you, **initial here:** ________

Receiving care from another eye doctor?___No___Yes (Name): __________________________

PRIMARY CARE PHYSICIAN & PHARMACY

Doctor Name:__________________________ Practice Name:_________________________
Office Phone: __________________________ Office Fax: ____________________________
Pharmacy (name & location): ____

REASON(S) FOR VISIT (CHECK ALL THAT APPLY):

___Yearly Eye Exam ___Eyeglasses ___Contact Lenses ___Medical Office Visit

EXAM OPTIONS:

___ The iHealth Wellness Exam (+$68):

RECOMMENDED BY YOUR EYE DOCTOR every 1 to 3 years (based on results) & of course, ALL NEW PATIENTS. (This includes the iCam Retina Photo at no additional cost.)

OR

___ The iCam Retina Photo Exam (+$39):

PERFORMED YEARLY to evaluate eye health. (This is the high-tech standard of care at an annual comprehensive wellness eye exam).

I authorize and request my insurance company pay directly to the doctor insurance benefits otherwise payable to me for any covered services that can be submitted to my carrier.

I acknowledge that whenever possible, medical insurance will be billed for medical office visits along with any associated procedures and that wellness visits will be billed to vision plans.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.

SIGNATURE:____ **DATE:** ___/___/_____

Give your i-Care visit some 4-thought

CHECK ALL DISTANCES FOR WHICH YOU WEAR GLASSES/CONTACTS:

Far **Reading** **Computer** **None**

How is your vision **with** your preferred vision correction for each distance?

Far:	Acceptable	May need improvement	Blurry
Near/Read:	Acceptable	May need improvement	Blurry
Computer:	Acceptable	May need improvement	Blurry

CHECK ALL THAT APPLY:

score: (____)

How often do you experience:	All the time (4)	Most times (3)	Half the time (2)	Some-times (1)	Never (0)
Itchy eyes?					
Eye redness?					
Watery eyes (tearing)?					
Gritty/sandy sensation?					
Fluctuating vision?					

CHECK ALL THAT YOU'RE EXPERIENCING RIGHT NOW:

	Eye pain		Eyestrain		Headache
	Double Vision		Burning		Discharge
	Poor Night Vision		Bothersome Glare		Light Sensitivity
	Total Vision Loss		Other: __________		**None of these**

Indications for dilation include but are not limited to: pertinent family/personal medical history, recent eye/head injury, abnormal tests results, or lack of iHealth Wellness Exam within 3 years. Not having a dilated eye exam when indicated and/or failing to attend a medical office visit may be detrimental to your health and vision.

Dilation is an important part of an eye exam. It opens the pupil to better evaluate eye health, but it has temporary side effects: Light sensitivity & blurred near vision that may last up to six hours. Please, only drive once comfortable with your vision.

Pupil dilation is not recommended for patients who are pregnant, nursing, or allergic to the dilating agents (proparacaine, phenylephrine/hydroxy-amphetamine hydrobromide, & tropicamide).

Initial which best represents your wishes:

_____ **NO** dilation eye drops today. If medically indicated, I shall schedule it to be done.

_____ **Discuss** dilation with my doctor **if medically indicated**. This may add up to 35 minutes.

PERSONAL INFORMATION & DEMOGRAPHICS

Preferred Name: ___________________________ DOB:_____/_____/__________

Street Address: ___________________________ Sex: Male _____ Female____

City/State:_________________/____________ Zip Code: ____________________

Occupation: ______________________________ Hobbies: ______________________

Handedness: ◯ Right ◯ Left Sports you enjoy: _______________________________

Preferred Number: _______________________, ◯ Mobile (text OK) ◯ Home ◯ Work

Email address:____

Approximate height in feet & inches: _____’ & _____” and weight in pounds: ______ lbs

Would you like to know if you are a good candidate for vision correction **without** eyeglasses, contact lenses, or eye surgery? ◯ Yes ◯ No

List any eye health concerns due to conditions of a grandparent or distant relative?
◯ No ◯ Yes, details: ____

FAMILY HISTORY:	**None**	Dad	Mom	Brother	Sister	Son	Daughter
Cancer:	◯	◯	◯	◯	◯	◯	◯
Unspecified Diabetes	◯	◯	◯	◯	◯	◯	◯
Type 1 Diabetes:	◯	◯	◯	◯	◯	◯	◯
Type 2 Diabetes:	◯	◯	◯	◯	◯	◯	◯
High Blood Pressure:	◯	◯	◯	◯	◯	◯	◯
Hyperthyroidism:	◯	◯	◯	◯	◯	◯	◯
Hypothyroidism:	◯	◯	◯	◯	◯	◯	◯
Cataract:	◯	◯	◯	◯	◯	◯	◯
Macular Degeneration:	◯	◯	◯	◯	◯	◯	◯
Glaucoma:	◯	◯	◯	◯	◯	◯	◯

SOCIAL HISTORY:

Do you drink alcohol? ◯ No ◯ Socially ◯ >2 drinks/day ◯ >5 drinks/day

Do you use illicit drugs? ◯ No ◯ Yes, details: ______________________________

Are you a current smoker? ◯ No ◯ Yes, how many cigarettes per day?
◯ < 4 cigs ◯ <1pack ◯ 1-2packs ◯ >2packs

If you used to smoke, for many years?_____ & how long ago did you quit?__________

COMPREHENSIVE REVIEW OF SYSTEMS (PERSONAL HISTORY)

Constitution:
__ **None**
__ Developmental Disabilities
__ Cancer
__ Fatigue Syndrome
__ Other: ______________________

Ear / Nose / Throat:
__ **None**
__ Hearing Loss
__ Sinusitis
__ Dry Mouth
__ Laryngitis
__ Other: ______________________

Neurological:
__ **None**
__ Multiple Sclerosis
__ Epilepsy
__ Cerebral Palsy
__ Tumor
__ Stroke / CVA
__ Migraine
__ Autism Spectrum Disorder
__ Other: ______________________

Psychiatric:
__ **None**
__ Depression
__ Attention Deficit
__ Anxiety Disorder
__ Bipolar Disorder
__ Other: ______________________

Cardiovascular:
__ **None**
__ Hypertension (high blood pressure)
__ Stroke / CVA
__ Heart Disease
__ Vascular Disease
__ Congestive Heart Failure
__ Other: ______________________

Respiratory:
__ **None**
__ Current cigarette Smoker
__ Asthma
__ Bronchitis
__ Emphysema
__ Chronic Obstruction
__ Sleep Apnea
__ Other: __________________

Gastrointestinal:
__ **None**
__Crohn's
__ Colitis
__ Ulcer
__ Acid Reflux
__ Celiac Disease
__ Other: __________________

Genitourinary:
__ **None**
__ Kidney Disease
__ Prostate Disease / Cancer
__ Benign Prostatic Hypertrophy
__ Pregnant
__ Nursing
__ Herpes
__ Chlamydia
Other:

Musculoskeletal:
__ **None**
__ Arthritis
__ Fibromyalgia
__ Muscular Dystrophy
__ Ankylosing Spondylitis
__ Osteoporosis
__ Gout
__ Other: __________________

Allergies (drug & environmental)**:**
__ **None**
____
____
____

Integumentary:
__ **None**
__ Eczema
__ Rosacea
__ Psoriasis
__ Herpes Simplex / Cold Sores
__ Herpes Zoster / Shingles
__ Other: __________________

Endocrine:
__ **None**
__ Type 2 Diabetes Mellitus
__ Type 1 Diabetes Mellitus
__ Thyroid Dysfunction
__ Hormonal Dysfunction
__ Other: __________________

Hematologic / Lymphatic:
__ **None**
__ Anemia
__ Large-volume blood loss
__ Ulcer
__ High Cholesterol
__ Other: __________________

Allergy / Immunology:
__ **None**
__ Drug Allergies
__ Environmental Allergies
__ Rheumatoid Arthritis
__ Lupus
__ Sjogren's Syndrome
__ Other: __________________

Current Medications:
__ **None**
____
____
____
____
____
____
____
____
____

Eyes:
__ **None**
__ Cataract
__ Glaucoma
__ Macular Degeneration
__ Dry Eye
__ Retinal Detachment
__ Worsening floaters
__ Flashes of light
__ LASIK/PRK/RK Surgery
__ Cataract Extraction
__ Corneal Transplant
__ Strabismus (cross-eye) Surgery