



# WELCOME TO OUR OFFICE

**Personal Information:**

Date: \_\_\_\_\_

Name: Last \_\_\_\_\_ First \_\_\_\_\_ Nickname \_\_\_\_\_ DOB \_\_\_\_\_ Guardian (if minor) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State **FL** Zip \_\_\_\_\_

Phone (H) \_\_\_\_\_ (C) \_\_\_\_\_ (W) \_\_\_\_\_

Email \_\_\_\_\_ (May we contact you via email? Y N ) (Your email will never be released to a 3rd party.)

How did you hear about our office?: Phonebook Internet Insurance Listing Personal Referral (name) \_\_\_\_\_

Insurance: VSP VCP EyeMed None Occupation \_\_\_\_\_ Hobbies \_\_\_\_\_

**I currently wear (circle all that apply):** Glasses Contacts Neither **This eye examination is for:** Glasses Contacts Other

Are you planning to purchase eyeglasses today?: Yes No Undecided

When was your last exam? \_\_\_\_\_ Previous doctor/optical \_\_\_\_\_

Briefly state which issues you are visually having \_\_\_\_\_

**Patient History: (In order to serve you better and help speed up the exam process please make sure the following sections are fully completed.)**

	Yes	No	Medication/Treatment		Yes	No	Medication/Treatment
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	_____	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	_____	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other retinal problems	<input type="checkbox"/>	<input type="checkbox"/>	_____	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lazy eye or eye turn	<input type="checkbox"/>	<input type="checkbox"/>	_____	Lung Disease/Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye Surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye infections or injuries	<input type="checkbox"/>	<input type="checkbox"/>	_____	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Color blindness	<input type="checkbox"/>	<input type="checkbox"/>	_____	Cancer (type)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Light sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	_____	Frequent Headaches	<input type="checkbox"/>	<input type="checkbox"/>	_____
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	_____	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	_____
Flashes or floaters	<input type="checkbox"/>	<input type="checkbox"/>	_____	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	_____

Other pertinent history: \_\_\_\_\_

List other medications you are taking: \_\_\_\_\_

Known drug or environment allergies: \_\_\_\_\_

**Family History:**

Has anyone in your family had the following? (Please note maternal or paternal grandmother/grandfather) (ie MGM /PGF or PGM/PGF)

	Yes	No	Family Members		Yes	No	Family Members
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	_____	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lazy eye or eye turn	<input type="checkbox"/>	<input type="checkbox"/>	_____	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	_____	Cancer (type)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	_____				

In case of an emergency, whom may we call today? Name \_\_\_\_\_ Tel \_\_\_\_\_ Relation \_\_\_\_\_

Patient/Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

## Notice of Privacy Practices

Eye Doctors of New Tampa  
19062 Bruce B Downs Blvd  
Tampa FL 33647  
(813) 632 2020

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our Office Administrator listed at the top of this page.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**THE EYEDOCTORS OF NEW TAMPA**  
19062 BRUCE B DOWNS BLVD. TAMPA, FL 34639

**Informed Consent for Dilation of Eyes and/or Optomap®**

Sight threatening conditions can happen to individuals of all ages and usually without symptoms. A condition with the potential for partial or total loss of vision may exist and go undetected without Dilation and/or the Optomap Retinal Exam.

Please check which procedure(s) you would prefer:

- Dilation**
- Eye drops necessary
  - Sensitivity to bright light
  - Blurry Vision, mostly near
  - Lasts 4-6+ hours (depending on sensitivity)
  - May not be able to drive or go back to work/school
  - Doctor examines retina and then makes notes in chart
  - Included in eye exam price
- Optomap® Retinal Exam**
- No drops
  - No blurry vision or any other side effects
  - Can resume normally activities after exam
  - Digital retinal image stored on computer for future comparison & baseline
  - Doctor reviews with patient during examination
  - OCCASIONALLY may still need dilation to examine other structures
  - Additional fee of \$39 (not covered by insurance)
- Would like to Discuss with Doctor**

Patient Printed Name \_\_\_\_\_

Signature (Patient/Guardian) \_\_\_\_\_ Date \_\_\_\_\_

In order to save time and provide the best eye care possible we pre-screen all patients with the Optomap®.