Welcome To Jones Eyecare Associates

Date: ____________________ Gender: M / F

Patient Name:____ Phone #_____________________

Address:____________________________________City:________________State:_____________Zip:___________

Age:_____DOB:_______________Please List any Vision Insurance:____

Date of Last Exam: _________ Do you wear glasses?___ Contacts:(if so,type)_______________________________

Do you have trouble seeing: Up close: _____Distance: _____

Any other problems with your eyes:____

Have you had any injury, illness, or diseases that have affected your eyes?_________________________________

General Health

Diabetes:___ Allergies/Sinus:___ Heart Problems:___ High Blood Pressure:___ Lung Problems:___ Headaches:___

Please list all current medications: ___________________________________Drug Allergies: ______________________

Family History

Glaucoma:___ Crossed eyed:___ Diabetes:___ Blindness:___ Other:____

For Office Use Only

Reason for visit GLX/CLX/Other:____ NP/FP Doctor______________

CL Brand: OD____ BC_______ 20/_______

OS____ BC_______ 20/_______

Habitual Rx OD____ 20/ ________

OS____________________________ ____________20/ ________ Add_________

Objective Rx OD_____________________________________

OS_____________________________________ NCT OD________OS__________

KER OD________/__________ OS________/__________

Unaided Acuities: OD 20/_______

OS 20/_______

Final Rx OD_____________________________________OS_____________________________________ Add______

HIPAA PRIVACY RELEASE AUTHORIZATION

Per Oklahoma State Title 63, Section 1-502 all information that identify any communicable or venereal disease is confidential. Due to Oklahoma State title 63, Section 1-502, Jones Eyecare Associates must receive written authorization from its patients prior to third-party individuals being present during time or examination. If you want or authorize anyone other than yourself to be present during your examination, or allow anyone other than yourself to pick up your prescription or contacts please complete the section below.

Protected Health Information Release Authorization

I understand that by granting this authorization the information that is discussed may include information, which may be considered a communicable, or venereal diseases, which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea, and the immunodeficiency virus.

I, ____, do/do not authorize the following
(Patient's Name)
persons to have access to my protected health information:

Name	**Relationship to patient**
1.	
2.	
3.	

In addition to a basic eye examination, it is strongly recommended that **ALL** patients undergo pupillary dilation in order to assure a thorough evaluation of ocular health. Without dilation of the pupil, all of the internal structures of the eye cannot be viewed. Anyone with symptoms of floaters, flashing lights, diabetes, hypertension, or history of eye disease are especially urged to undergo this supplemental examination. The effects of dilation include light sensitivity and blurred vision which can last up to 8 hours. **THE FEE FOR DILATION IS $25.00**

I understand the importance of pupillary dilation and
(Please Circle One) Do / Do Not
Want to have this procedure today.

This office offers retinal photography. Although this technology is not a substitute for a dilated eye exam, it is an excellent tool to evaluate internal eye health **WITHOUT** dilation. A baseline photo is highly recommended for all patients and ongoing photo documentation is recommended for anyone at risk of progressive eye diseases such as glaucoma, diabetic or hypertensive retinopathy or macular degeneration. **THE FEE FOR RETINAL PHOTOGRAPHY IS $15.00.**

I (Please circle one) DO / DO NOT want to have this procedure today.

I have read and consent to the above information and acknowledge receipt of Privacy Policies and practices of Jones Eyecare.

Signature: ______________________________ **Date** ____________________