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: _____ Occupation: _____

Any other problems with your eyes? _____

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

General Health

Diabetes: y___ n ___ Allergies/Sinus: y___ n ___ Heart Problems: y___ n ___ High Blood Pressure: y___ n ___

Lung Problems: y___ n ___ Headaches: y___ n ___ Pregnant: y___ n ___ Other Conditions: _____

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 Stat 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 of examination.

If you want to 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 nor 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.	

As well as a basic eye examination, it is strongly recommended that all patients undergo pupillary dilation in order to assure a thorough evaluation of ocular health. Those patients with a history of floaters, flashing light, and/or a family history of diabetes, high blood pressure, or any type of eye disease are especially urged to undergo this supplemental examination. **THERE IS AN ADDITIONAL $25.00 FEE FOR DILATION.**

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

Glaucoma is the leading cause of preventable blindness in the U.S.A. We strongly recommend that all of our patients receive the GDxVCC screening exam. It is especially important if you have glaucoma or a family history of glaucoma, a strong eyeglass prescription, are over age 40, African American, have an unexplained vision loss, or have high intraocular pressure. This state of the art procedure takes approx. 2 minutes of your time, **AND THERE IS AN ADDITTIONAL CHARGE OF $19.00.**

I understand the importance of GDxVCC screening and
(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_____

Santa Fe Office Only