Welcome to Camden Eye Care

Please fill out information pertaining to the patient. If you have any questions, please ask one of our caring staff for assistance.

PATIENT INFORMATION: Date: _____ Home Ph: _____ Work Ph: _____ Cell Ph: _____

E-mail: _____

Mr. Mrs. Ms. Dr. _____ _____ _____ _____
(PATIENTS FIRST NAME) (M.I.) (LAST NAME) (NICKNAME)

Address: _____ Apt/Ste: _____ City/State/Zip: _____ Sex: M F

Date of Birth: ___/___/___ Social Security #: ___-___-___ State Drivers License # _____

Emergency Contact Person: _____ Relationship: _____ Phone: _____

Occupation: _____ Number of Hours on Computer: _____

Employer: _____ Hobbies: _____

Additional Family Members Living At Home: Spouse: _____ Age: ___

Child: _____ Age: _____ Child: _____ Age: _____ Other: _____ Age: _____

Child: _____ Age: _____ Child: _____ Age: _____ Other: _____ Age: _____

GENERAL HEALTH HISTORY:

How Is Your General Health? _____ Environmental Allergies: _____

Current Medications: (Specify name, dosage, frequency. Example: Zocar, 5mg, Once daily) _____

_____

Known Medication Allergies: _____ Name of Family Doctor: _____, M.D. Last Visit: _____

	Yes	No			Yes	No			Yes	No			Yes	No
Diabetes				Cancer				Thyroid Problems				Use Cigarettes/Tobacco		
Hypertension				Heart Problems				Are You Pregnant				Use Alcohol?		
Arthritis				Kidney Problems				Liver Problems				Other Substances?		
Respiratory Problems				H.I.V. Positive				(If yes, please notify the doctor)						

OCULAR HEALTH HISTORY:

Reason For Today's Visit: _____ When Was It First Noticed? _____

	Yes	No			Yes	No			Yes	No	Family History
Sinus Problems				Double Vision				Glaucoma			
Headaches				Burn, Itch, Tear				Cataract			
Eye Injuries				Recent Eye Infection				"Lazy Eye"			
Eye Surgeries				Use Eye Drops				Macular Degeneration			
Light Flashes/Floaters				Name of Drops				Retinal Detachment			

Date of Last Eye Examination: _____ Last Eye Doctor: _____

CONTACT LENS HISTORY:

Do you have or have you ever worn contact lenses: __No __Yes If yes, what type: __Soft __Rigid Gas Permeable __Toric __Bifocal __Other

Wearing Time Today: _____hours Do you sleep in contact lenses (extended wear): __No __Yes If yes, how many days at a time_____

How often do you dispose them: __Daily __Two Weeks __Monthly __Quarterly __Yearly __Never

Would you like new contact lenses today? __No __Yes: Which type_____

THIS SECTION MUST BE ANSWERED AND SIGNED

VISUAL FIELD TEST: A highly advanced computerized instrument that provides a more thorough visual field screening. This instrument checks for loss of sight in both the central and peripheral areas. Visual field testing can assist us in the early detection of glaucoma, retinal problems and some neurological diseases such as brain tumors and optic nerve disease. It also enables us to better diagnose causes for headaches. Your insurance does not cover this service. **There is an additional fee of $20.00 for this test. PUPIL DILATION:**. Dilation allows the doctor to thoroughly examine the inside of the eyes for diseases such as cataracts, glaucoma, retinal diseases ocular tumors, and diabetic retinopathy. We use eye drops that take about 20-30 minutes to fully dilate your pupils. Side effects are blurred vision up close and light sensitivity. It takes approximately 4-6 hours to recover from dilation. Unlikely side effects from dilation could be a sharp sudden rise in the pressure of your eyes, creating an ocular emergency. If we determine you are at risk for dilation, your pupils will not be dilated. You will usually be able to drive home.

I consent to: Visual Field Yes No X_____ **DILATION Yes No X**_____

METHOD OF PAYMENT: (Please Circle) Cash Credit Card

-PLEASE NOTE PAYMENT IN FULL IS REQUIRED ON DAY OF SERVICE UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE-

MEDICAL /VISION INSURANCE: YES NO (If yes, please circle one):Aetna, Block Vision, BCBS, Cigna,Davis Vision, Eyemed, Medicaid, Medicare, Spectera, Superior Vision, UHC, VCP, VSP, other _____

ASSIGNMENT OF BENEFITS: I hereby assign payment of authorized Medicare or other insurance to which I am entitled to be made to Dr. Tran for any services provided. The assignment will remain in effect and full force until revoked by me in writing. A photocopy of this assignment is deemed valid as the original. I fully understand and accept that I am financially responsible for all fees and charges whether or not paid by your insurance provider. I hereby authorize said assignee to release all information necessary to secure the payment.

Signature (Patient or Guardian):X _____ **Date** _____