Dr. Scott Lewis, O.D. & Associates

Please help us keep our records current by updating this form at each visit.

First Name _____ MI ____ Last Name _____ Date of Birth _____

Mailing Address _____ City _____ State _____ Zip Code _____

Home Phone # _____ Cell Phone # _____ E-mail Address (used for recall purposes) _____

Responsible party & relationship if patient is a dependent _____

How did you hear about us? (Examples: walk-in, referral, internet search, previous Costco exam, insurance) _____

Approx. date of last eye exam?_____ Location of last eye exam?_____

Main purpose of today's visit?_____

Do you currently wear glasses?_____ Do you currently wear contact lenses?_____

Are you interested in wearing contact lenses?_____ Lasik vision correction?_____

Ocular Health – please circle any of the following that apply to you:
Floaters Flashes Dryness Redness Pain Itching Eye strain Double Vision Lasik Injury Infection Cataract Glaucoma Macular Degeneration Other:_____

Please list medications you are taking and what they are being taken for:_____
_____

Please list any significant medical conditions not listed above:_____
_____

Please list any medications that you are allergic to:_____

Family History – please circle any of the following that are in your direct bloodline:
Diabetes Glaucoma Macular degeneration Blindness Other:_____

Federal law requires you be made aware of your privacy rights regarding personal medical information. By signing you acknowledge that you have been offered a copy of the federal HIPAA privacy policies, and that **you have read and understand the exam fee policy sheet.** Your signature will also serve as a "signature on file" allowing us to bill your insurance if you are asking us to do so.

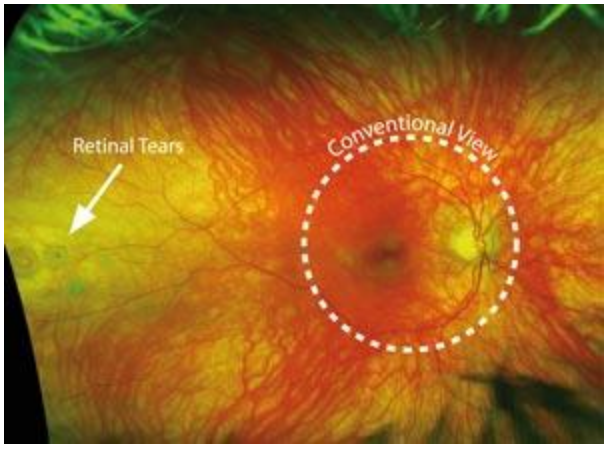
_____ _____
Patient/Guardian's Signature Date

optomap® Retinal Exam

Dr. Lewis & Associates offers a state-of-the-art digital scanning technology that allows us to view the inside of your eye **without the use of dilation drops in most cases**. The OPTOMAP allows us to evaluate your retina for problems such as retinal tears, retinal detachments, retinal tumors, macular degeneration, hypertension, and diabetic retinopathy. This scanning system is completely safe for kids and adults and does not emit radiation like an X-ray.

Dilated Exam	**vs.**	**Optomap Exam**
1. Blurred near vision for 4 – 6 hours		1. No blurred vision
2. Light sensitivity for 4 –6 hours		2. No light sensitivity
3. Longer office visit to wait for drops		3. Images can be captured in 0.25 of a second
4. No permanent record of retina		4. Permanent record of retina for future comparison
5. Only the doctor can see the retina		5. You can see your retina!

Problems such as undiagnosed retinal tears can lead to retinal detachment and potential loss of vision in the affected eye.



OPTOMAP view

We recommend that **ALL** patients have a thorough examination of their retina during their routine eye exam. **Without the Optomap or the dilated examination, the doctor cannot fully assess the health of the back of your eyes.** There is an additional fee of $25 for the Optomap. In most cases, this procedure is not covered by insurance.

_____ I elect to have an Optomap ($25) and understand it is not required but recommended by Dr. Lewis.

_____ I prefer a dilated exam of my retina and I have been informed of the side effects listed above.

_____ I do not wish to have either the Optomap or dilation performed, and understand the risks involved.

_____ I wish to speak with the doctor first before making a final decision.

_____ _____

Patient Signature Date