DR. GORDON RUSSELL, O.D. DR. IAN KIRSTE, O.D. DR. MATTHEW WEBB, O.D.

PATIENT'S LEGAL NAME:

Last_____First_____MI_____

DOB_____Social Security#_____

Address_____City_____State_____Zip_____

Home#_____Cell#_____Text OK?_____E-mail_____

PLEASE PROVIDE E-MAIL FOR ANY COMMENTS OR SUGGESTIONS

☐ Male ☐ Female ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Occupation/Hobbies_____

ARE YOU USING INSURANCETODAY? ☐ YES ☐ NO

ARE YOU HERE FOR A CONTACT LENS EXAM? ☐ YES ☐ NO

PRIMARY INSURANCE/PERSON RESPONSIBLE FOR PAYMENTS:

Name of Insured/Guarantor_____

DOB_____Social Security#_____ Relationship_____

Health Ins. Co_____Vision Co_____

Employer_____

Address(if different from patient)_____

Home#_____Cell#_____Text OK?_____E-mail_____

YES NO

Secondary Insurance

Name of Insured/Guarantor_____

DOB_____Social Security#_____ Relationship_____

Health Ins. Co_____Vision Co_____

Employer_____

Address(if different from patient)_____

Home#_____Cell#_____Text OK?_____E-mail_____

DUE TO CONSTANT CHANGES AND VARIETIES OF INSURANCE PLANS, YOU WILL NEED TO PRESENT INSURANCE CARD TO THE RECEPIONIST EACH TIME YOU VISIT OUR OFFICE. IF YOU DO NOT HAVE YOUR CARD, PLEASE EXPECT TO PAY FOR THE VISIT. WHEN INSURANCE INFORMATION IS RECEIVED, WE WILL FILE FOR YOU.

MEDICAL HISTORY

Name:_____ DOB:_____

List Current Medications(including eye medication)

_____

_____

_____

Any medication allergies? _____

_____

Last Eye Exam _____

Medical Dr. Name _____

Medical Dr. Phone _____

Last Medical Exam _____

Any known eye disease? _____

_____

List of Medical Surgeries? _____

_____

Are you pregnant or nursing No❑ Yes❑

Do you currently wear Glasses or Contacts? (Circle)

Is there a Family History of:

	(Relationship To You)
Blindness	_____
Cataracts	_____
Crossed Eyes	_____
Glaucoma	_____
Macular Degeneration	_____
Retinal Detachment	_____
Arthritis	_____
Cancer	_____
Diabetes	_____
Heart Disease	_____
High Blood Pressure	_____
Kidney Disease	_____
Lupus	_____
Thyroid Disease	_____
Other	_____

REVIEW OF SYSTEMS

Do you currently have, or have you ever had any problems in the following area?

	No	**Yes**
Constitutional		
Fever/Weight Loss/Gain	❑	❑
Cardiovascular/Vascular	❑	❑
Vascular Disease	❑	❑
High Blood Pressure	❑	❑
Ears, Nose, Mouth, Throat	❑	❑
Allergies/Hay Fever	❑	❑
Sinus Congestion	❑	❑
Respiratory	❑	❑
Asthma	❑	❑
Gastrointestinal	❑	❑
Diarrhea	❑	❑
Constipation	❑	❑
Genitourinary	❑	❑
Genitals/Kidney/Bladder	❑	❑
Musculoskeletal	❑	❑
Arthritis	❑	❑

Integumentary	**No**	**Yes**
Skin	❑	❑
Neurological		
Headaches	❑	❑
Migraines	❑	❑
Seizures	❑	❑
Endocrine		
Diabetes	❑	❑
Thyroid/Other Glands	❑	❑
Hematologic/Lymphatic		
Anemia	❑	❑
Bleeding Problems	❑	❑
Allergic/Immunologic	❑	❑

Eyes	**No**	**Yes**
Loss of Vision	❑	❑
Distorted Vision	❑	❑
Loss of Side Vision	❑	❑
Itching	❑	❑
Burning	❑	❑
Foreign Body Sensation	❑	❑
Excess Tearing/Watering	❑	❑
Glare/Light Sensation	❑	❑
Chronic Infection of Eye Lid	❑	❑
Sties or Chalazion	❑	❑
Flashes/Floaters in Vision	❑	❑

Do you use eye drops?

❑*No* ❑ *Yes -what type?* _____

Do your eyes feel dry, painful, or sore?

❑ *Never* ❑ *Sometimes* ❑ *Often* ❑ *Always*

Do you ever experience episodes or periods of blurred vision?

❑ *Never* ❑ *Sometimes* ❑ *Often* ❑ *Always*

How often do your eyes feel tired?

❑ *Never* ❑ *Sometimes* ❑ *Often* ❑ *Always*

Do you have problems with your eyes when you are working on a computer, watching TV or reading?

❑ *Never* ❑ *Sometimes* ❑ *Often* ❑ *Always*

SOCIAL HISTORY

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

❑ Yes, I would prefer to discuss my Social History with the doctor.

Do you drive? ❑No ❑ Yes if yes, do you visual difficulty when driving?

_____

Do you use tobacco products? ❑No ❑Yes

If Yes, type/amount how long:_____

Do you use drink alcohol? ❑No ❑Yes

If Yes, type/amount/how long:_____

Do you use illegal drugs? ❑No ❑Yes

If Yes, type/amount/how long:_____

Have you ever been exposed to or infected with:

❑ Gonorrhea ❑Hepatitis ❑ HIV ❑Syphilis

Acknowledgment of Notice of Privacy Practices

SkyView Eye Care
3450 E. Main Farmington New Mexico 87402
5053257070

The law requires that SkyView Eye Care make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

____I was given the opportunity to read, have read or had explained to me SkyView Eye Care's Notice of Privacy Practice prior to any services offered.

___ The Notice of Privacy Practice could not be read due to the emergent nature of the care and will be acquired when possible

I authorize SkyView Eye Care to release my personal health information to the following individuals:

_____ _____
_____

Our office may use texts and emails to communicate with you. Although HIPAA compliant, they may not be encrypted and complete privacy cannot be guaranteed.

___ I authorize the use of text and email.

___ I do not authorize the use of text and email to communicate with me.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

_____/_____
Patient Signature / Date

If you are signing as a personal representative of the patient, please indicate your relationship. If you are signing for a minor, you attest that you have the legal authority to make medical decisions for the minor and consent to such care. Please indicate any other parent, step-parent, guardian or other individual(s) authorized to make medical decisions for the minor.

_____ / _____
Representative Signature / Relationship to Patient

_____
_____
Other individuals authorized to make legal decisions for the minor

Automated Visual Field Test $10.00

Virtually all of the major causes of blindness in the United States can be detected by the changes in the visual field.

A new and highly sophisticated computerized instrument enables us to provide a more thorough visual field screening analysis. The instrument checks for areas of loss of sight both in central and peripheral areas. Visual field testing can assist us in the early detection of glaucoma, retinal problems, some neurological diseases (**such as brain tumors and optic nerve diseases**), and enables us to better diagnose the causes of headaches. Most visual field defects are not noticed by an individual until very late stages, we are committed to the prevention of eye disease and wish to stress that **early detection** can significantly increase the chance of curing a disorder or at least minimize the effect.

We strongly recommend that all of our patients receive this test as part of their comprehensive visual analysis. **Having this test administered will add $10.00 to the cost of the eye exam. Please check the appropriate are below stating your preference and sign this form at the bottom.**

- ❒ **I want** the Visual Field Screening (NOT COVERED BY INSURANCE)
- ❒ **I do not want** the Visual Field Screening

Dilated Retinal Exam $35.00

Dilating the pupil with eye drops allows us to obtain a much better view inside the eye in order to better detect such problems as glaucoma, cataracts, retinal detachment, macular degeneration, diabetes, and high blood pressure, often before obvious symptoms. We strongly recommend pupil dilation if you have never had them dilated or if any of the following applies to you:

- You are over the age of 55
- Have a family history of eye disease or health problems
- Recent onset of unusual visual symptoms such as floaters, flashes, pain or blurred vision.
- You have a high spectacle prescription.
- It has been more than two years since your last dilated retinal exam

While the drops used to dilate pupils have minimal side effects, some people may experience some mild blurred vision, especially when reading, and some sensitivity to light for three to four hours or more. **Having this test administered will add $35.00 to the cost of the eye exam. Please check the appropriate box below stating your preference and sign this form at the bottom.**

- ❒ **I want** a dilated retinal examination. (COVERED BY SOME INSURANCE) **please verify with the front desk.**
- ❒ **I do not want** a dilated retinal examination.
- ❒ I will reschedule for a dilated retinal examination.

(Required) Retinal Photographs $25.00

Our Digital Retinal camera is capable of high-resolution retinal photography that captures more than 80% (200 degrees) of the inside of the eye. **These photos will be a permanent part of your electronic records; allowing the doctor to diagnose and manage eye diseases more accurately and will be a part of your yearly eye exam. Effective 4/1/2023 all patients will be required to have a comprehensive eye examination with retinal imaging. Patients using vision insurance will be required to pay a fee of $25.00 in addition to the copay.**

Signature: _____ **Date:** _____