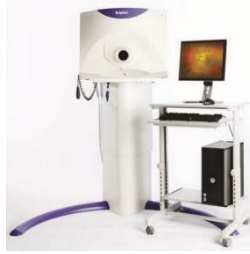
Retinal Imaging by Optos



Dr. Waldman strongly suggests this high-quality digital camera photograph of the retina. This technology allows us to view almost the entire retinal surface with one picture, as compared to numerous smaller views that are pieced together in a dilated examination. This information is then stored permanently for future comparison.

Because the Dr. can view almost the entire surface in one view, it is easier to detect potential problems such as a growth or tumor in the retina, as well as small blood spots on the retinal surface that may be due to undetected diabetes or other medical problems. Subtle beginning macular degeneration is easier to detect as well.

Of course, there is the obvious advantage of saving time and not having any blurred vision after the office visit.

In some cases, dilation may be needed to be used in conjunction with the photograph in order to view a specific area of the retina with a magnified 3D view.

The cost of procedure is $30 (usually not covered by insurance).

We pride ourselves with providing our patients with the highest standard of care, and the doctor believes Optomap is a tool that enhances the quality of your examination.

I would like this test at my visit.

____ ____________

____ ____________

____ ____________

I DO NOT want this test at my visit.

____ ____________

____ ____________

____ ____________

Please bring your current glasses to your appointment.
Contact lens wears please wear your contacts in for your appointment and have them in at least 4 hours.

Patient History Questionnaire

What has prompted you to make this appointment? Is it a routine exam or do you have a current concern regarding your eyes or vision? Please explain in detail.

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____

If you are a new patient, when was the approximate date of your last eye exam?

____

Is there anything that has occurred with your eyes in the past that the Doctor needs to know about such as a lazy eye, any eye surgeries, past injuries, infections or vision loss, etc.?

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____

Is there a family history of cataracts, glaucoma, macular degeneration, retinal detachment or other eye problems? Please list all that apply.

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Please provide the name of your primary care provider and any other Doctors that you are currently seeing and the reason you are seeing them.

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____

Do you have diabetes and / or high blood pressure? If so, for how long?

____

____

Please list all prescription medications you are taking and for what medical condition(s) they are prescribed for

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____

____

____

Please list any allergies to medications that you have

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____

____

New Contact Lens Patients

Please list the details of your current contact lens prescription

Lens Brand____

Power____

Base Curve (BC) ____________________________________

Please bring the boxes if you have them or the location of your last eye exam including the phone number.

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge I received/was offered a copy of Erie Optical Notice of Privacy Practices.

Patient Name (Please Print) ________________________

Signature __________________________________

Please check the if patient is a minor and you are parent or guardian _____

May we leave a message on your answering machine or at your home with a member of your household? Yes____ NO _____

I give permission for information regarding my medical records to be discussed with the person(s) below.

With ______________________________

Relationship __________________________________

Patient insurance information

Vision Insurance Carrier ____

Circle If You Have
VSP
(Not Necessary To Fill In)

Address and phone ____

____

Member Name ____

Employer ____

Insurance ID number ____________________ Group number __________

Medical Insurance Carrier ____

Address and phone ____

____

Member Name ____

Employer ____

Insurance ID number ____________________ Group number __________

I hereby authorize payment directly to Erie Optical. I understand I am financially responsible for any charges not covered by this authorization. I also understand Erie Optical will submit a claim for my services rendered today, however it is my responsibility to ensure my claim is paid in a timely manner. If my insurance company has not paid this claim within sixty (60) days I will be responsible for the balance and will be reimbursed when the insurance company pays the claim.

Patient Signature ____

Printed Name ____

Erie Optical

Dry Eye Questionnaire - Please rate the following symptoms.

Have you experienced any of the following *during the last week*?	All of the time	Most of the time	Half of the time	Some of the time	None of the time
1. Eyes that are sensitive to light? . .	4	3	2	1	0
2. Eyes that feel gritty?	4	3	2	1	0
3. Painful or sore eyes?	4	3	2	1	0
4. Blurred vision?	4	3	2	1	0
5. Poor vision?	4	3	2	1	0

Have problems with your eyes limited you in performing any of the following *during the last week*?	All of the time	Most of the time	Half of the time	Some of the time	None of the time	N/A
6. Reading?	4	3	2	1	0	N/A
7. Driving at night?	4	3	2	1	0	N/A
8. Working with a computer or bank machine (ATM)?	4	3	2	1	0	N/A
9. Watching TV?	4	3	2	1	0	N/A

Have your eyes felt uncomfortable in any of the following situations *during the last week*?	All of the time	Most of the time	Half of the time	Some of the time	None of the time	N/A
10. Windy conditions?	4	3	2	1	0	N/A
11. Places or areas with low humidity (very dry)?	4	3	2	1	0	N/A
12. Areas that are air conditioned? . . .	4	3	2	1	0	N/A