EDGE OPTICS PATIENT PAPERWORK

PATIENT INFORMATION:

NAME: _____ TODAY'S DATE: _____ MALE/FEMALE

DATE OF BIRTH: _____ SS# _____ OCCUPATION: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ E-MAIL: _____

LAST EYE EXAM: _____ LAST MEDICAL EXAM: _____

VISION INSURANCE PLAN NAME: _____ PRIMARY MEMBER'S NAME _____

INSURANCE ID NUMBER: _____ (IF YOU HAVE THIS INFORMATION AVAILABLE)

ARE YOU HERE FOR GLASSES? Y/N ARE YOU HERE FOR CONTACTS? Y/N BRAND OF CONTACTS:_____

I UNDERSTAND THAT UNDER MOST CIRCUMSTANCES, YEARLY CONTACT LENS EVALUATION ARE AN ADDITIONAL CHARGE:_____(PLEASE INITIAL)

DO YOU HAVE ANY ALLERGIES TO MEDICATIONS? YES/NO IF SO, LIST:_____

MEDICATIONS CURRENTLY TAKING: _____

ARE YOU CURRENTLY PREGNANT? YES/NO

HAVE YOU HAD ANY EYE SURGERIES OR TRAUMA TO THE EYES? _____

DO YOU SEE FLASHES OF LIGHT, BLINDSPOTS IN VISION, OR BLACKOUTS? _____

PATIENT MEDICAL HISTORY:

DO YOU SUFFER FROM:		HAVE YOUR EYES SUFFERED FROM:		HAS YOUR FAMILY SUFFERED FROM:	
HIGH BLOOD PRESSURE	YES☐ NO☐	STRABISMUS	YES☐ NO☐	BLINDNESS	YES☐ NO☐
DIABETES	YES☐ NO☐	LAZY EYE	YES☐ NO☐	GLAUCOMA	YES☐ NO☐
LUNG DISEASE	YES☐ NO☐	KERATOCONUS	YES☐ NO☐	DIABETES	YES☐ NO☐
SEIZURES	YES☐ NO☐	GLAUCOMA	YES☐ NO☐	CATARACTS	YES☐ NO☐
CANCER	YES☐ NO☐	DIABETIC RETINOPATHY	YES☐ NO☐	MACULAR DEGENERATION	YES☐ NO☐
LUPUS	YES☐ NO☐	MACULAR DEGENERATION	YES☐ NO☐	KERATOCONUS	YES☐ NO☐
RHEUMATOID ARTHRITIS	YES☐ NO☐	DRY EYES	YES☐ NO☐		
SARCOIDOSIS	YES☐ NO☐	IRITIS	YES☐ NO☐		
MULTIPLE SCLEROSIS	YES☐ NO☐	RETINAL DETATCHMENT	YES☐ NO☐		
HIGH CHOLESTEROL	YES☐ NO☐	CATARACTS	YES☐ NO☐		

WHAT SPORTS/HOBBIES ARE YOU INVOLVED IN? _____

WHAT PROTECTIVE EYEWEAR DO YOU USE FOR YOUR INTERESTS? _____

How Did You Hear About Edge Optics?

☐Google ☐Yelp ☐Social Media ☐Friend:_____ ☐Other _____

PLEASE INITIAL AND SIGN YOUR ACKNOWLEDGEMENT OF THE FOLLOWING:

_____(INITIAL) ONLY POLYCARBONATE AND TRIVEX LENS MATERIALS ARE IMPACT RESISTANT. WE ARE REQUIRED TO MEET ANSI Z-87 STANDARDS FOR SAFETY GLASSES, FOR CHILDRENS GLASSES OR ANYONE WHO MAY BE AT RISK OF EXPERIENCING FREQUENT IMPACT TO THE EYES AND FACE.

_____ (INTIAL) UV BLOCKING LENSES ARE RECOMMENDED FOR EVERYONE DUE TO THE DAMAGE EYES EXPERIENCE FROM UV LIGHT EXPOSURE. INTENSITY OF EXPOSURE INCREASES WITH ALTITUDE AND WHEN ON REFLECTIVE SURFACES SUCH AS SNOW AND WATER.

_____ (INITIAL) HARMFUL BLUE LIGHT FILTERING IN EYEGLASS LENSES MAY BE RECCOMMENDED TO ALIVIATE DIGITAL EYE STRAIN AND PHYSICAL DAMAGE CAUSED BY THE BLUE UV LIGHT EMITTED BY DIGITAL SCREENS.

_____ (INITIAL) I HAVE READ AND AGREE TO THE TERMS OF THE ATTACHED HIPAA PRIVACY PRACTICES AND UNDERSTAND MY RIGHTS*****

_____ (INITIAL) I HAVE READ AND AGREE TO THE TERMS OF THE ATTACHED WARRANTY AND RETURN POLICY*****

*****Please notify us if you would like a copy for your records

I HAVE READ AND UNDERSTAND THE ITEMS I INITIALED ABOVE (SIGN BELOW):

_____

FIELD OF VISION TESTING

Edge Optics recommends field of vision testing on all patients over the age of 12 on a yearly basis as an important part of your eye examination. Missing pieces to your field of vision may not be detectable under normal eye exam procedures. The field of vision testing can assist in the early detection of glaucoma, optic nerve disease, retinal disorders, and neurological issues like brain tumors.

The fee for this important test is $15, most vision insurances do not cover this cost. Please initial one of the following:

___ Yes, I give consent for completion of testing.

___ No, I decline to have the field of vision testing performed.