

# EDGE OPTICS PATIENT PAPERWORK

## PATIENT INFORMATION:

NAME: \_\_\_\_\_ TODAY'S DATE: \_\_\_\_\_ MALE / FEMALE

DATE OF BIRTH: \_\_\_\_\_ SS# \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE: \_\_\_\_\_ E-MAIL: \_\_\_\_\_

CONTACT PREFERENCE:      PHONE CALL       TEXT       EMAIL

LAST EYE EXAM: \_\_\_\_\_ LAST MEDICAL EXAM: \_\_\_\_\_

VISION INSURANCE PLAN NAME: \_\_\_\_\_ PRIMARY MEMBER'S NAME \_\_\_\_\_

INSURANCE ID NUMBER: \_\_\_\_\_ OR LAST 4 OF PRIMARY'S SSN: \_\_\_\_\_

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

I UNDERSTAND THAT FOR AN UPDATED CONTACT LENS PRESCRIPTION,  
AN ANNUAL CONTACT LENS EVALUATION IS REQUIRED BY LAW AND IS 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 <input type="checkbox"/> NO <input type="checkbox"/>	STRABISMUS                    YES <input type="checkbox"/> NO <input type="checkbox"/>	BLINDNESS                    YES <input type="checkbox"/> NO <input type="checkbox"/>
DIABETES                    YES <input type="checkbox"/> NO <input type="checkbox"/>	LAZY EYE                      YES <input type="checkbox"/> NO <input type="checkbox"/>	GLAUCOMA                    YES <input type="checkbox"/> NO <input type="checkbox"/>
LUNG DISEASE              YES <input type="checkbox"/> NO <input type="checkbox"/>	KERATOCONUS                YES <input type="checkbox"/> NO <input type="checkbox"/>	DIABETES                    YES <input type="checkbox"/> NO <input type="checkbox"/>
SEIZURES                    YES <input type="checkbox"/> NO <input type="checkbox"/>	GLAUCOMA                    YES <input type="checkbox"/> NO <input type="checkbox"/>	CATARACTS                    YES <input type="checkbox"/> NO <input type="checkbox"/>
CANCER                      YES <input type="checkbox"/> NO <input type="checkbox"/>	DIABETIC RETINOPATHY    YES <input type="checkbox"/> NO <input type="checkbox"/>	MACULAR DEGENERATION YES <input type="checkbox"/> NO <input type="checkbox"/>
LUPUS                        YES <input type="checkbox"/> NO <input type="checkbox"/>	MACULAR DEGENERATION YES <input type="checkbox"/> NO <input type="checkbox"/>	KERATOCONUS                YES <input type="checkbox"/> NO <input type="checkbox"/>
RHEUMATOID ARTHRITIS YES <input type="checkbox"/> NO <input type="checkbox"/>	DRY EYES                      YES <input type="checkbox"/> NO <input type="checkbox"/>	
SARCOIDOSIS              YES <input type="checkbox"/> NO <input type="checkbox"/>	IRITIS                         YES <input type="checkbox"/> NO <input type="checkbox"/>	
MULTIPLE SCLEROSIS    YES <input type="checkbox"/> NO <input type="checkbox"/>	RETINAL DETACHMENT    YES <input type="checkbox"/> NO <input type="checkbox"/>	
HIGH CHOLESTEROL      YES <input type="checkbox"/> NO <input type="checkbox"/>	CATARACTS                    YES <input type="checkbox"/> NO <input type="checkbox"/>	
COLORBLINDNESS        YES <input type="checkbox"/> NO <input type="checkbox"/>	LIGHT SENSITIVITY        YES <input type="checkbox"/> NO <input type="checkbox"/>	

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.

\_\_\_\_\_(INITIAL) 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 EYEGLOSS LENSES MAY BE RECOMMENDED TO ALLEVIATE 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

\_\_\_\_\_(INITIAL) I UNDERSTAND THAT PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED.

EDGE OPTICS DOES ACCEPT HSAs/FSAs, AND CARECREDIT AS A FINANCING OPTION.

I HAVE READ AND UNDERSTAND THE ITEMS I INITIALED ABOVE

SIGNATURE X \_\_\_\_\_

## 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, only Medicaid covers 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.**