

BETTNER VISION

(Please Print)

Date: _____

Last Name: _____ First: _____

Address: _____ City: _____ State: _____ Zip: _____

Sex: M F Age: _____ Date of Birth: ____/____/____ SSN ____ - ____ - ____

Home Ph# (____) ____ - ____ Fax # (____) ____ - ____ Work # (____) ____ - ____

E- Mail: _____ When was your last eye exam? ____/____/____

Occupation: _____ Employer: _____ Responsible party: _____

How did you hear about us? _____ Have you ever been in our office before? Y N

Wear glasses? Y N Computer glasses? Y N For? Distance Near Constantly

Contacts? Y N Dry Eyes? Y N Allergies? Y N _____

Are you interested in: Contact lenses Lasik Vision Care

Do you currently have prescription / UV protection glasses? Y N

Insurance Information (if applicable):

Vision Insurance: _____ Phone #: (____) ____ - ____

Policy Holder's (PH) Name: _____ PH ID#: _____

PH Date of birth: ____/____/____ PH SSN: ____ - ____ - ____

Employer's Name: _____

Computer / Internet Usage:

Do you have any of the following while working on the computer? headaches burning eyes
 blurry vision dry eyes sore eyes halos body aches Other: _____

Do you have a separate pair of computer glasses? Y N

How long are you on a computer? _____ Hours/day _____ days a week

Patient's concerns / problems: _____

PATIENT INFORMATION

Last Name: _____ First Name: _____ Date: ___ / ___ / ___

HIGHLY RECOMMENDED EVERY YEAR

At our practice we have a highly sophisticated, computerized visual field analyzer. Routine eye exams unfortunately do not detect many diseases in their early stages. However, the visual field analyzer can detect diseases such as pituitary tumors, glaucoma, retinal and macular degeneration, optic nerve disease, retinal disturbances due to vascular problems or medications. While checking the pressure inside the eye is important, it may not by itself detect early glaucoma. We strongly recommend that all of our patients receive this evaluation. It is especially important for those patients that have a history of high blood pressure, diabetes, headaches, migraines, floaters, a high spectacle or retinal problems. This state-of-the-art procedure requires an additional 10 minutes, *and there is a nominal fee of \$25.00.*

YES NO Consultation needed

HIPPA – Due to the Health Insurance Portability and Accountability Act legislation which protects patient’s information laws, we must have your written authorization to release your medical and billing information to a person / boy (e.g. Family, insurance companies, health care professionals, legal personnel, et cetera) other than yourself. Understand your information may need to be discussed with your current physician and/or any other medical facility in regards to the scheduling of procedures, testing or surgery. This release will be valid for one year from the date of signing.

Notice of Privacy Practices – I acknowledge receipt of Bettner Vision’s privacy document.

Fee Sign Off – Fees may be less due to insurance allowances. If insurance claim is denied, patient is responsible for payment in full.

Eye Glass Exam	\$79.00
Visual Field	\$25-170
Contact Lens Exam (depending on complexity of fit)	\$49 / \$69
Contact Lens Year Supply	

THE SIGNATURE BELOW ACKNOWLEDGES THAT THE PATIENT HAS READ AND AGREED TO ALL OF THE ABOVE SECTIONS.

Patient Signature: _____ **Date:** ___ / ___ / ___

Patient History

What is the reason for your visit? _____

<p>Do you wear glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you wear contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Are you here for glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Are you here for Contact Lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>When was your last eye exam? _____</p> <p>Do you use a computer? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you have any allergies to medication? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list:</p> <p>Do you suffer from seasonal allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Are you taking any medications? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, LIST MEDS:</p> <p>Are you taking any eye medications? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, List:</p> <p>Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you see flashes of lights in your eyes? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you see floating objects in your eyes? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you suffer from temporary blackouts of your vision? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Do you suffer from: <input type="checkbox"/> None</p> <p><input type="checkbox"/> High Blood Pressure</p> <p><input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> Lung Disease</p> <p><input type="checkbox"/> Seizures</p> <p><input type="checkbox"/> Cancer</p> <p><input type="checkbox"/> Lupus</p> <p><input type="checkbox"/> Rheumatoid Arthritis</p> <p><input type="checkbox"/> Sarcoidosis</p> <p><input type="checkbox"/> Multiple Sclerosis</p> <p><input type="checkbox"/> HIV</p> <p>Have your eyes ever suffered from: <input type="checkbox"/> None</p> <p><input type="checkbox"/> Glaucoma</p> <p><input type="checkbox"/> Retinal Disease</p> <p><input type="checkbox"/> Optic Nerve Disease</p> <p><input type="checkbox"/> Strabismus (eye turn)</p> <p><input type="checkbox"/> Amblyopia (lazy eye)</p> <p><input type="checkbox"/> Dry Eyes</p> <p><input type="checkbox"/> Diabetic Retinopathy</p> <p><input type="checkbox"/> Macular Degeneration</p> <p><input type="checkbox"/> Keratoconus</p> <p><input type="checkbox"/> Iritis</p> <p><input type="checkbox"/> Retinal Detachment</p>	<p>Have you had previous eye surgery for: <input type="checkbox"/> No</p> <p><input type="checkbox"/> Cataract</p> <p><input type="checkbox"/> Retinal Detachment</p> <p><input type="checkbox"/> Muscle Surgery</p> <p><input type="checkbox"/> Trauma</p> <p><input type="checkbox"/> Refractive Surgery</p> <p><input type="checkbox"/> Foreign Body Removal</p> <p><input type="checkbox"/> Other:</p> <p>Has anyone in your family suffered from: <input type="checkbox"/> No</p> <p><input type="checkbox"/> Glaucoma Relationship:</p> <p><input type="checkbox"/> Cataracts Relationship:</p> <p><input type="checkbox"/> Blindness Relationship:</p> <p><input type="checkbox"/> Diabetes Relationship:</p> <p><input type="checkbox"/> Macular Degeneration Rel:</p> <p><input type="checkbox"/> Keratoconus Relationship:</p> <p>Medical History from Reviewed: _____</p> <p><input type="checkbox"/> NO CHANGES</p> <p>Doctor Initials:</p>
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Informed Consent for the Dilated Fundus Exam

Medical research indicates that many people need their pupils dilated to rule out any eye disease that may cause the loss of their sight or worse. The dilated fundus examination is recommended for all patients who are new to the practice, diabetics, those with high blood pressure or lupus, those with symptoms of flashes or floaters, those with a history of retinal problems, those who are highly near-sighted, those with a history of cancer, those having experienced blunt head trauma within 5 years, those with unexplained headaches, those with unexplained visual acuity loss, or at your doctor's discretion.

The drops that are used to dilate your pupils require about 20 minutes to take effect and will keep your pupils dilated for 2 to 4 hours. However, your near vision will improve in 1-2 hours. The dilation will cause your vision to be temporarily blurry. Also, your eyes will be sensitive to sunlight, possibly making driving home and continuing your day's activities somewhat difficult, even with sunglasses. Therefore, if necessary, we can reschedule your dilation for a more convenient time.

Side effects from the drops rarely occur, but if you should experience ANY PAIN IN OR AROUND YOUR EYES, HAZY VISION (halos around lights) OR A SICK FEELING, PLEASE CONTACT THE DOCTOR IN OUR OFFICE AS SOON AS POSSIBLE.

Please check one: I want to have the dilation done today. I DO NOT want the dilation today

Signed: _____

Date: _____