Patient Information

New ***Estb***

Last Name: _____ First Name: _____ Middle Initial: _____

Phone #: _____ Age: _____ DOB: _____

Email: _____

Please check all that apply

Eye Concerns:

___ redness
___ tearing
___ burning
___ discharge

Visual Concerns:

___blurred vision
___ eye pain
___ eye strain
___ double vision
___ total loss of vision

___ severe sensitivity to light
___ headache
___ poor night vision
___ bothersome night glare
___ struggle for grades in school

Eye Conditions:

self	blood relative		
___	___	glaucoma	last eye exam _____
___	___	blindness	
___	___	macular degeneration	last dilation _____
___	___	lazy eye	
___	___	dry eye	last physical exam _____

Medical History:

self	blood relative		self	blood relative			
___	___	diabetes	___	___	heart disease	___	pregnant/nursing
___	___	cancer	___	___	hypertension	___	alcohol use
___	___	arthritis	___	___	respiratory problems	___	smoker
___	___	headache	___	___	shingles	___	eye surgery
___	___	HIV	___	___	thyroid disease	___	medication allergies
___	___	hepatitis	___	___	high cholesterol		
___	___	lupus	___	___	kidney disorder	_____	

Current Medications:

_____

_____

Contact Lens Wear:

Brand: _____ Replacement Schedule: ___daily ___ 2 weeks ___ monthly ___ other

Do you sleep in your contacts? ___ yes ___ no Cleaning solution used: _____

Glasses Wear:

Do you currently wear glasses? ___ yes ___ no Age of glasses? _____

Troubles or concerns with your current glasses?

_____

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Pupil Dilation:
Dilation is standard procedure for a comprehensive eye examination. Dilation assists in the detection of glaucoma, cataracts, diabetic and hypertensive retinal changes, retinal holes or tears, and some types of tumors and headaches. Dilating drops enlarge the size of the pupil and allows the doctor a more thorough examination of the retina (back of the eye). The side effects are light sensitivity for 3 to 6 hours and trouble focusing up close for 2 to 3 hours. It is possible, though unlikely, that a dilation could cause a sudden rise in eye pressure. If the doctor determines you are at risk your pupils will not be dilated. Most people are able to drive home, however, if you are uncomfortable driving, or if you feel unsafe driving, please arrange for someone else to drive you. Dr. Swift prefers to dilate ALL patients, especially if this is your first time to visit our office.

signature: _____ Date: _____

iWellness:
The iWellness is a quick non-invasive scan that allows Dr. Swift to see beneath the surface of your retina. This scan can help detect the beginning stages of various eye diseases. For more information please read attached sheet. The iWellness scan is typically NOT covered by vision or medical insurance. The $30 charge will be added to the cost of your visit today.

I AGREE to iWellness _____YES _____NO

Medical Information Release Form:
(HIPAA Release Form)

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

Spouse _____ DOB: _____

Child(ren) _____ DOB: _____

Other _____ DOB: _____

( ) Information is NOT to be released to anyone.

This release of information will remain in effect until termination by me in writing.

Signed: _____ DOB: _____

Printed name and relationship of gaurdian (for minors):

_____