Welcome To Our Office — Rodney Johnson, O.D.

Date: _______________

First Name ______________________________ Last Name ____

Birth Date________________ Age _____ ☐ Male ☐ Female If patient is a child, Parents Name ______________________

Mailing Address______________________________ City______________________ State______ Zip__________

Primary Phone # ____________________ ________ ☐ Cell ☐ Home Occupation_____________________________

Email address ____

Emergency Contact Phone _____________________ Name: ______________________ Relationship____________

Reason for today's visit

(Check all that apply)

☐ Routine Exam

☐ I want a glasses prescription

☐ I want a contact lens prescription

☐ Vision Problem

☐ Red Eye

Other (Please Explain) ___________________________

____

Previous Eye history

Have you been seen at this location? ☐ Yes ☐ No

Date of last exam_____________ Dr. _____________

Do you wear contact lenses? ☐Yes ☐ No

Have you experienced or been treated for any of the following. Check all that apply:

☐ Cataracts ☐ Glaucoma ☐ Crossed Eye ☐ Lazy Eye

☐ Macular Degeneration ☐ Retinal Detachment ☐ Eye Surgery _

☐ LASIK or PRK or RK ☐ Eye injury ☐ Color blindness

Are you currently experiencing any of the following? Check all that apply:

☐ Blurry vision ☐ Eye strain/tired eyes ☐ Headaches related to eyes ☐ Double Vision ☐ Trouble seeing at night

☐ Problems with Glare ☐ Sunlight sensitivity ☐ Excess watering/tearing ☐ Redness ☐ Itching ☐ Burning ☐ Dryness

☐ Floating spots ☐ Flashes of light

Family Medical History

(Mother, Father, Brothers, Sisters, Grandparents)

☐ Diabetes ☐ High blood pressure ☐ Glaucoma ☐ Retinal disease ☐ Macular disease ☐ Heart Disease

☐ Stroke ☐ Asthma ☐ Cancer ☐ Multiple Sclerosis ☐ Color blindness ☐ Night blindness ☐ Lazy/Crossed eye ☐ Cataracts

☐ Eye/Muscle imbalance

Medical Information

Primary care Doctor ___________________________ Last visit to physician ________________

List of medications (include non prescription)

____

Are you allergic to any medications? ☐ No ☐ Yes If yes please list ________________________________

HIPAA Compliance Acknowledgement

A copy of the offices Notice of Privacy Practice has been provided for my review and I understand that it is my right to have a take home copy.

Patient/Guardian Signature____ Date: ______________________

Systems Review. Check all those that apply to you:

☐ Diabetes ☐ High Blood Pressure ☐ Heart Disease ☐ Stroke ☐ High Cholesterol

☐ Autoimmune Disorders ☐ Thyroid Dysfunction ☐ Stomach problems ☐ Kidney Disease ☐ Allergies

☐ Fibromyalgia ☐ Sinus Problems ☐ Other Ear/Nose Throat Conditions ☐ Blood Disorders ☐ Anemia

☐ Skin Conditions ☐ Arthritis ☐ Neurological Conditions ☐ Migraines ☐ Seizures ☐ Depression

☐ Anxiety ☐ Asthma ☐ Sleep Apnea ☐ Cancer (type:______________) ☐ Pregnant ☐ Nursing

☐ Smoker ☐ Occasional use of alcohol ☐ Use recreational drugs ☐ *None of these apply to me*

What are your interests or hobbies? (Check all that apply)

☐ Smart phone usage ☐ Computers ☐ Television ☐ Video Games ☐ Swimming ☐ Aviation

☐ Outdoor Sports ☐ Reading ☐ Golf ☐ Sewing/crafts

Dilated Retinal Exam:

Dilation (enlargement) of the pupils allows for a more thorough assessment of the eye's internal health. It is recommended as part of a complete eye examination without which, certain diseases may not be discovered. The side effects of blur and light sensitivity generally last 4 -6 hours. There is no extra fee for dilation:

Do you want to have your eyes dilated today? ☐ Yes ☐ No
If no, I understand that a condition with the potential for total vision loss may exist and without dilation may go undetected. I decline to have my eyes dilated and I assume the risks of refusal:
Signature: ____________________________________ Date: ___________

iWellness Exam: ***Not part of basic exam $17 additional fee***
Early detection of eye diseases is crucial. We provide advanced technology in retinal screening. Like a dental X-Ray without the radiation, it allows for early detection of sight threatening disease such as macular degeneration, glaucoma, diabetic retinopathy and many other retinal conditions.

- Provides a digital computerized retina map.
- Gives in depth view of the retinal layer (where disease can start)
- We will show you your image today during the exam.
- A permanent record for your medical file – allowing for year to year comparison for tracking and diagnosing potential eye disease.
- Is fast, easy and comfortable. Will NOT require dilating drops
- We encourage all our patients to have a iWellness exam annually.

☐ I want the IWellness Exam
☐ I decline the iWellness Exam and am aware this limits our ability to accurately document the health of your eyes
_____ **Initials**

If you are using vision insurance today please fill out the following:

Insurance Company:____________________________________ Primary Insured's Name:___________________________________

Primary Insured's Date of Birth: ___________ Primary Insured's SSN/Member ID: __________________________

I authorize payment for my vision benefits directly to Dr. Johnson. I agree that if payment is denied I will be financially responsible for all outstanding charges. Authorization obtained at the time of services does not guarantee payment.

PATIENT/Guardian Signature: ____ Relation to patient: ______________