Buenau's Opticians Inc

Family History

Is there any family medical history of any of the following? **(If yes please list the relationship to you)**

Cataracts	□Yes □No		Diabetes	□Yes □No	
Glaucoma	□Yes □No		High Blood Pressure	□Yes □No	
Lazy Eye	□Yes □No		Retinal Detachment	□Yes □No	
Macular Degeneration	□Yes □No		Color Blindness or other	□Yes □No	

Patient Insurance Information

Vision Insurance Carrier _____
ID # _____
Policy Holder's Name _____
Policy Holder's DOB _____

Medical Insurance Carrier _____
ID # _____
Policy Holder's Name _____
Policy Holder's DOB _____

Contact Lens Medical Management

For your health and safety, we perform annual contact lens evaluations. A separate contact lens fee is charged beyond the comprehensive eye examination. We determine fit, health and condition of the eyes with contact lenses. We also evaluate changes in prescription and lens design during this process.

Authorization to pay benefits to physician.

I hereby authorize payment directly to the doctor for benefits to ME for services received. I understand that I am responcible for the balance of fees not paid by the insurance.

I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF BUENAU'S OPTICIANS NOTICE OF PRIVACY PRACTICES.

Please sign below that you have reviewed all of the information above and on the reverse side and it is correct to the best of your knowledge.

Signature _____ ***Date*** _____

Signature _____ ***Date*** _____

Signature _____ ***Date*** _____

Signature _____ ***Date*** _____

*****For office use only below this line*****

Doctor's Signature _____ Date _____

Date Updated					
Doctor's Initials					

Buenau's Opticians Inc

Identifying Information

Last Name _____ First Name _____ MI _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ Date of Birth _____
Occupation _____ Employer _____ SS# _____
Parent/Gaurdian _____ Emergency Contact and Phone _____
Email Address _____
Cell Phone _____

Patient Eye History

What is the major purpose of this visit? _____
Date of Last Eye Exam ___/___/___
Do you currently wear contact lenses? ☐ Yes ☐ No What brand of contacts do you wear? _____
Are you interested in contact lenses today? ☐Yes ☐ No Are you interested in LASIK? ☐Yes ☐No ☐Maybe

Have you ever been diagnosed or treated for the following?

Cataracts ☐ Yes ☐ No
Glaucoma ☐ Yes ☐ No
Macular Degeneration ☐ Yes ☐ No
Retinal Detachment ☐ Yes ☐ No
Lazy eye or Eye turn ☐ Yes ☐ No
Eye Injury ☐ Yes ☐ No
Eye Surgery ☐ Yes ☐ No

Do you experience any of the following?

Blurry Vision ☐ Yes ☐ No
Headaches ☐ Yes ☐ No
Double Vision ☐ Yes ☐ No
Flashes of Light ☐ Yes ☐ No
Persistent Floaters ☐ Yes ☐ No
Eye Itching ☐ Yes ☐ No
Eye Burning ☐ Yes ☐ No
Eye Tearing ☐ Yes ☐ No

Patient Medical History, Review of Systems, Social History

Name of Family Physician _____ Telephone _____
Please list any Allergies to Medications ☐None _____
Please list any Medications or Vitamins that you are currently taking ☐None _____

Have you ever been diagnosed or treated for any of the following problems?

			Explanation of Problem
Endocrine- thyroid, hormones, glands	☐ Yes	☐ No	
Cardiovascular – heart, blood vessels	☐ Yes	☐ No	
High Blood Pressure	☐ Yes	☐ No	
Respiratory- lungs, breathing	☐ Yes	☐ No	
Gastrointestinal- stomach/ intestines	☐ Yes	☐ No	
Genitourinary- genitals, kidneys, bladder	☐ Yes	☐ No	
Musculoskeletal- muscles, joints, arthritis	☐ Yes	☐ No	
Integument- skin	☐ Yes	☐ No	
Neurological- migraine, seizures	☐ Yes	☐ No	
Psychiatric	☐ Yes	☐ No	
Ears, Nose, Mouth or Throat	☐ Yes	☐ No	
Hematologic/Lymphatic- anemia, bleeding	☐ Yes	☐ No	
Allergic/ Immunologic	☐ Yes	☐ No	
HIV/AIDS	☐ Yes	☐ No	

Do you have Diabetes? ☐Yes ☐No What year were you diagnosed? _____ Type 1☐ or 2☐ ? What was your last HbA1c? _____

Do you use tobacco products? ☐Yes ☐No If yes, type/amount/how long? _____
Do you drink alcoholic beverages? ☐Yes ☐No If Yes, type/amount/how long? _____
Are you currently Pregnant or Nursing? ☐Yes ☐No

Please list any other medical conditions you have that are not listed above _____

Please turn this form over and complete side two

BUENAU'S Opticians Inc.

Optomap Imaging Information & Authorization

Here at Buenaus Opticians Inc. we strive to provide the newest technology and best medical care possible. We proudly offer the Optomap Daytona technology to assist in retinal examination. As a non-invasive and instantaneous procedure, the Optomap is highly recommended and is an alternative to pupil dilation for many patients.

When your pupils are dilated with drops, your vision can be impaired, your eyes become very light sensitive, and the doctor is able to view only a 45 degree snapshot of your eye at a time. The Optomap takes a more sophisticated, ultra-wide digital image of your retina, allowing an even more thorough examination of your eyes. This in-depth photograph allows our doctor to better examine, evaluate, and treat your eye health. The image also provides a permanent physical documentation of the retina.

The Optomap retinal imaging can assist in diagnosing and treating:

Retinal Problems, Macular Degeneration, Glaucoma, Optic Nerve Diseases, Retinal Detachments, Diabetes, High Blood Pressure, Cardiovascular Disease, and Precancerous and Cancerous Lesions.

Our Doctors strongly encourage all of their patients to have the Optomap performed annually at their comprehensive eye health examination. Dilating eye drops are generally not needed with the Optomap, so your vision will not be blurry or light sensitive, allowing you to drive comfortably after your exam.

There is an additional fee of $35 for the Optomap retinal imaging, as it is not covered by insurance companies. This fee is due at the time of your exam service. It is an eligible expense for FSA/HSAaccounts.

Patient Name: _____ Date: _____

____ I elect to have the Optomap Retinal Screening

____ I decline to have the Optomap Retinal Screening

Signature: _____