

Optical Intuitions • Dr. Amanda Misinco, O.D.  
Welcome to our office!

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M.I. \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ SS#(last 4 digits) \_\_\_\_\_  
Daytime Phone # \_\_\_\_\_ Alternate Phone # \_\_\_\_\_ email \_\_\_\_\_  
Occupation/Employer \_\_\_\_\_ Male Female Preferred Contact? Phone Email  
Emergency Contact (Name/Phone #) \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
How did you hear about us? \_\_\_\_\_

**INSURANCE**

Name of VISION Insurance \_\_\_\_\_ Primary Member Name \_\_\_\_\_  
Primary Member ID# \_\_\_\_\_ Primary Member Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Primary Member Employer \_\_\_\_\_ Patient Relationship to Primary: Self Spouse Child Other  
Name of MEDICAL Insurance \_\_\_\_\_ Primary Member Name \_\_\_\_\_  
Primary Member ID#(Social Security # if using Medicare) \_\_\_\_\_ Group# \_\_\_\_\_

**EYE AND HEALTH HISTORY**

Reason for Today's Visit \_\_\_\_\_  
Date of Last Eye Exam \_\_\_\_\_ Do you currently wear: Glasses Contacts Sunglasses  
Contact Lens Brand \_\_\_\_\_ Type: Spherical Astigmatism Monovision Bifocal  
Daily Electronic Device Usage (i.e. computer, tablet, cell phone, video games, etc.) \_\_\_\_\_ hours  
Hobbies/Sports: \_\_\_\_\_  
Current Medications (Please include eye meds, vitamins and over-the-counter products) \_\_\_\_\_

Drug Allergies \_\_\_\_\_ Other Allergies \_\_\_\_\_

**Eye History**

Have you experienced or been diagnosed with the following? (circle Y or N)

Y / N Eye Injury	Y / N Excessive Tearing	Y / N Glaucoma
Y / N Eye Surgery (Cataract / LASIK / Eye Muscle)	Y / N Excessive Itching	Y / N Macular Degeneration
Y / N Double Vision	Y / N Flashes of Light/Floaters	Y / N Retinal Detachment
Y / N Excessive Irritation	Y / N Loss of Vision	Y / N Lazy Eye (Amblyopia)
	Y / N Cataracts	Y / N Headaches

**General Health History**

Have you ever been diagnosed with any of the following? (circle Y or N)

Y / N High Blood Pressure	Y / N Cancer	Y / N Gastrointestinal
Y / N High Cholesterol	Y / N Asthma/Respiratory	Y / N Neurological
Y / N Diabetes	Y / N Thyroid (low / high)	(i.e. Multiple Sclerosis, ALS)
Y / N Heart Disease	Y / N Arthritis	
Y / N Stroke	Y / N Kidney Disease	

Other Medical Conditions: \_\_\_\_\_

Do you use? Tobacco Alcohol Recreational Drugs N/A  
Are you pregnant or nursing? Yes No Height \_\_\_\_\_ Weight \_\_\_\_\_

Primary Care Doctor \_\_\_\_\_ Phone/Fax Number \_\_\_\_\_

**Family Health History**

Has anyone in your family ever been diagnosed with any of the following? (circle Y or N)

- |                            |                           |                      |
|----------------------------|---------------------------|----------------------|
| Y / N Cataracts            | Y / N Blindness           | Y / N Stroke         |
| Y / N Glaucoma             | Y / N High Blood Pressure | Y / N Cancer         |
| Y / N Macular Degeneration | Y / N High Cholesterol    | Y / N Thyroid        |
| Y / N Retinal Detachment   | Y / N Diabetes            | Y / N Arthritis      |
| Y / N Lazy Eye             | Y / N Heart Disease       | Y / N Kidney Disease |

Other Family Medical Conditions: \_\_\_\_\_

**RETINAL EXAMINATION**

**Pupil Dilation:** Dilation is recommended every 1 to 2 years to fully assess the health of your eyes. Pupil dilation allows a comprehensive evaluation of the back of the eye and aids in the diagnosis and monitoring of various eye conditions. Dilation is typically indicated for patients with a previous diagnosis or family history of diabetes, high blood pressure, high cholesterol, cataracts, glaucoma, retinal detachment, or macular degeneration. Dilation also helps determine a more accurate prescription in young patients. Side effects can last up to 4 hours, and include sensitivity to bright lights and blurry near vision. Most patients are able to drive dilated, but extra caution is advised.

**Digital Retinal Photography:** A retinal photograph is a high resolution picture that provides an in-depth view of the retinal surface. It is used as a tool to screen for eye diseases and to document, review, and compare your retina over time. This retinal screening is fast and comfortable, as it does not require dilation drops. Retinal photography is not a substitute for dilation, but is used in conjunction with dilation to monitor subtle changes in the retina over time. Recommended annually, the digital retinal screening is performed as an enhancement to the general eye examination, and is typically *NOT* covered by insurance.

- I ACCEPT to have my eyes dilated today. *(Covered by Insurance.)*
- I ACCEPT the digital retinal screening today. *(\$35 fee.)*
- I DECLINE pupil dilation, but do understand its importance.

**ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES (HIPAA)**

I acknowledge that I received a copy of the Notice of Privacy Practices pertaining to Optical Intuitions and the office of Dr. Amanda S. Misinco, O.D. (Copies available upon request.)

Signature \_\_\_\_\_ Date \_\_\_\_\_

**ACKNOWLEDGEMENT OF FINANCIAL POLICIES**

I authorize the release of medical and other information acquired in the course of my examination and/or treatment to the necessary insurance companies, third party payors, and/or other health practitioners required to participate in my care. I authorize and request my insurance company to make direct payment to Optical Intuitions and Dr. Amanda Misinco, O.D. I understand that I am financially responsible for charges not covered by my insurance plan.

\*Accepted forms of payment: Cash, Check, Visa, Mastercard, American Express, Discover, Care Credit.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**CONTACT LENS EVALUATION AND FITTING**

Contact lenses are considered prescription medical devices with a limited useful lifespan. Contacts must be evaluated **annually** by the doctor to ensure they fit the eye correctly and will not compromise ocular health.

Although your vision insurance may provide a discount for this service, there is typically an out-of-pocket charge. The fee for this evaluation will range from **\$60 to \$125**, depending on the type of contact lens you need.

A contact lens evaluation is **required** to finalize and/or renew your prescription. In some cases, the doctor may require a follow-up visit after your trial lenses have been dispensed. Follow-up visits are included with the initial fitting fee for a period of **30 days**. Follow-up visits beyond **30 days** may be charged as an additional fee.

Contact lens prescriptions are written for a **maximum** one-year supply of lenses, and will only be released after returning for follow-up as recommended by the doctor.

Signature \_\_\_\_\_ ESTIMATED FEE: (based on your insurance plan)  
Date \_\_\_\_\_