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)_____

Home Phone #_____**Mobile Phone #**_____ **email**_____

Occupation_____ **□Male □Female □N/A** **Preferred Contact? □Phone □Email**

Emergency Contact (Name/Phone #)_____**Relationsip 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#(or *New* 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_____ **Contact Lens Solution**_____

Contact Lens 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**	Y / N **Excessive Itching**	Y / N **Macular Degeneration**
(Cataract / LASIK / Eye Muscle)	Y / N **Flashes of Light/Floaters**	Y / N **Retinal Detachment**
Y / N **Double Vision**	Y / N **Blindness**	Y / N **Lazy Eye** (Amblyopia)
Y / N **Eye Dryness**	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 conjuction 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 insurace.

□ **I ACCEPT to have my eyes dilated today.** ***(Covered by Insurance.)***
□ **I ACCEPT the digital retinal screening today.** ***($39 fee.)***
□ **I DECLINE pupil dilation, but do understand its importance.**

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, 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 **$76 to $150**, 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 _____ _____