JOHNSON i-CARE

PATIENT INFORMATION FORM

PATIENT INFORMATION – Please complete all information and print legibly.

□ MR □ MRS □ MS □ DR

Last Name	**First Name**	**Middle**	□ Male □ Female	**Birth Date**	**Age**
Address		**City**		**State**	**Zip Code**
Home Phone		**Work Phone**		**Social Security Number**	
E-mail		**Occupation**		**Hobbies**	
Employer/ School		**Address**			
Referred By		**Vision Insurance –** Company Name / I.D. or Health Care # _____ □ Eye Med □ BCBS □ Superior Vision □ VSP □ Other_____			
Signature		**Name of Parent/Guardian of Minor Patient.** Please Print.		**Date**	

PATIENT HISTORY – Please complete all information and print legibly.

- Primary reason for today's visit: _____
- Date of last eye exam: _____ By Dr.: _____ Age of best glasses: _____
- Name of primary physician, Dr:_____ Date of last medical exam: _____
- Have you visited our office before? □ Yes □ No If yes, Dr.: _____ When: _____
- Have your eyes been dilated before? □ Yes □ No If yes, when: _____ Adverse reaction Y / N
- Have you ever had retinal imaging taken? □ Yes □ No If yes, when: _____
- Are you currently pregnant? □ Yes □ No If yes, how far along: _____
- Are you being treated for any medical condition? □ Yes □ No If yes, which ones: _____
- Are you taking any medications? □ Yes □ No If yes, please list on provided sheet.
- Are you taking any eye drops? □ Yes □ No If yes, Over The Counter or Prescribed? (Circle)
  If yes, which ones: _____
- Are you allergic to any other medication / drop? □ Yes □ No If yes, which ones: _____
- Do you work on a computer? □ Yes □ No If yes, how many hours daily: _____
- Please check any / all health conditions that apply:

	Self	Relative		Self	Relative		Self
Diabetes	□	□	Thyroid Problems	□	□	Dryness / Eye Pain	□
Cataracts	□	□	Asthma	□	□	Blurred Vision	□
Glaucoma	□	□	Heart Disease	□	□	Headaches	□
Retinal Disease	□	□	Lung Disease	□	□	Double Vision	□
Eye Disease	□	□	High Blood Pres.	□	□	Eye Infection	□
						Eye Surgery	□

CONTACT LENS INFORMATION

- Have you ever worn contact lenses? □ Yes □ No
- If you currently wear contact lenses, please answer the following:
  - How often usually do you change out a pair of contact lenses for new? _____
  - Lens Type: □ Sphere □ Astigmatism □ Multifocal □ Monovision □ Rigid Gas Perm
  - Lens Replacement Schedule: □ Daily Disposable □ Bi-weekly □ Monthly
  - How do your lenses feel by 5 pm? □ Great □ Good □ Okay □ Dry □ Irritated □ Unbearable
- Are you interested in trying a new brand/type of contact lenses? □ Yes □ No

Turn Page

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1. 3-D Retinal Imaging and O.C.T. Scan

Our mission is to serve you with the most valuable and advanced vision care technology available today. Our doctors use state of the art 3-D digital imaging of your retina, as an alternative to dilating drops. TOPCON 2000 high-resolution technology creates a magnified 3-dimensional image to **rule out** problems including glaucoma, cataracts, macular degeneration, hypertension and diabetic retinopathy, as well as childhood ocular diseases and more. This imaging has a 2nd technology incorporated called O.C.T (Ocular Coherence Tomography), to provide scans of tissue layers well below your retina to detect earliest stage pathology not seen by simple eye dilation. We get a permanent printable record of your retina and optic nerve to further evaluate any changes over time. Our doctors **highly recommend** it for all of our patients.

The cost for this advance medical technology is an **extra $20** for every patient, with or without insurance. Most vision insurance plans have a $39 patient co-pay for this service because it is a valuable test. We elect to charge only $20 instead to keep the cost affordable to all of our patients, given our doctors feel very strongly that this technology has far reaching benefits to your overall eye health from the inside out.

If you'd rather be dilated, simply inform our front desk staff. We will need to give you a written consent form for dilation. Our doctors **must** be able to see into the inside of your eye by way of either the retinal imaging or pupil dilating drops, not just to see the outside to give you a prescription. Without seeing into the inside of your eyes, the doctors cannot diagnose eye problems in time to save your vision. Blindness causing diseases **cannot** be seen by just looking at your eyes externally, and these diseases are usually not symptomatic until it is too late to help.

Yes, I prefer 3-D retinal imaging instead of dilation: _____

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2. Visual Field Screening (This is a Separate Test than the Imaging Test Above)

The Visual Field screening evaluates both the central and peripheral/side vision. This technology allows the doctor to detect blind spots, which could be caused by optic nerve damage, glaucoma, strokes, tumors and other pathology. This test checks the health of your visual path from your eyes through your optic nerve to the brain. Our doctors recommend all patients receive the Visual Field Screening as a vital component of their comprehensive eye examination.

The charge for this evaluation is **$15.00**, which is not covered by insurance.

Yes, I would like to receive Visual Field Screening _____

No, I choose not to receive Visual Field Screening _____

Patient's Signature Date