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Welcome to our practice!

This letter will familiarize you with our office procedures and make your first appointment an enjoyable and worthwhile one.

The First Appointment

The first appointment usually takes from 45 to 90 minutes depending on which tests are needed (subsequent visits tend to be much shorter). You will need to bring the enclosed papers and your health insurance cards with you to this appointment. Do not mail back.

We usually dilate the pupils on the first visit, thus it is usually best to bring someone to drive you home.

Please bring with you a list of your medications (form enclosed) and any other information, which may help us in your treatment.

Referrals and Co-pays

If your insurance (usually an HMO type) requires a referral from your primary care physician – a written referral or authorization number must be in our office prior to your visit. Obtaining this authorization is the **responsibility of the patient.**

Any required co-pay or unmet deductible will be collected. We accept cash, checks, Visa, Mastercard and Discover.

Attention: Legal guardian/parents

If you have power of attorney over someone please bring a copy for the patient's records.

If someone other than the parent is bringing a child, the enclosed form will need to be filled out.

Thank you for your confidence in us.



PATIENT HISTORY RECORD

Have you ever been treated for any medical conditions (e.g., diabetes, high blood pressure, heart disease, etc.)?

Yes ___ No ___ If yes, please explain _____

Have you ever had any eye disease (e.g., glaucoma, cataract, etc.)?

Yes ___ No ___ If yes, please explain _____

Have you ever had any surgery?

Yes ___ No ___ If yes, please explain _____

Do you take any medications?

Yes ___ No ___ If yes, please list them on the accompanying medication sheet.

Do you have any drug allergies?

Yes ___ No ___ If yes, please explain _____

REVIEW OF SYSTEMS

Do you have any of the following problems: Yes No If yes, please explain:

Tuberculosis (active or inactive) ___ ___ _____

Immunodeficient disease ___ ___ _____

Hepatitis (any form) ___ ___ _____

Heart problems (e.g., chest pain, irregular heart beat) ___ ___ _____

Respiratory problems (e.g., shortness of breath, wheezing) ___ ___ _____

Gastrointestinal problems (e.g., heartburn, abdominal pain) ___ ___ _____

Urinary problems (e.g. pain, blood in urine) ___ ___ _____

Ear/nose/throat problems (e.g., hearing loss, sinus disease) ___ ___ _____

Musculoskeletal problems (e.g., arthritis) ___ ___ _____

Chronic fever, unexpected weight loss or gain, fatigue) ___ ___ _____

Skin problems (e.g., rash, excessive dryness) ___ ___ _____

Neurological problems (e.g., numbness, weakness, headache) ___ ___ _____

Psychiatric problems (e.g., depression, anxiety) ___ ___ _____

FAMILY AND SOCIAL HISTORY

Do any medical or eye diseases run in your family (e.g., diabetes, high blood pressure, glaucoma, cataract)?

Yes ___ No ___ If yes, please explain _____

Do you smoke? Yes ___ No ___ _____ packs per day

Do you drink alcohol? Yes ___ No ___ _____ drinks per day

FAMILY PHYSICIAN _____

DATE

CHART NUMBER

PATIENT NAME

