WELCOME TO THE OFFICE OF
DR. KIRT PATEL & ASSOCIATES

Name: ____ Birth Date: __________ Age: ___ Date: ___________

Check □ **No Change** in personal info. ~~ How did you hear about us?: ______________________________________

Address: ____ City: _______________ State: ______ Zip: ________

Primary Phone:(_____)___________________ phone type: _______ Alternative:(_____)___________________ phone type: _______

E-mail Address:____

Do you **want** Contact Lenses? ***Yes*** or ***No***; Clear Contact Lenses or Color Contact Lenses or Both (Please circle)

Do you **wear** Contact Lenses? ***Yes*** or ***No***; what Brand (Power, Size, Color): ________________________________

Contact Lens Fitting Consent >> **IF YOU DO NOT WANT CONTACT LENS, then SKIP this paragraph** <<

I, the patient, assume all risks and responsibilities of wearing and maintaining my contact lenses. I will **return on time for all follow-up visit(s)** as directed by my eye doctor so that the contact lenses can be properly fitted to my eyes. Otherwise, there is an additional charge if I do not come back for follow-up visit(s) on time or if any extenuating circumstances require additional follow-up visits **beyond two months**. I will follow my eye doctor's contact lens wearing schedule and cleaning schedule as directed so that I will not compromise the health of my eyes. I assume the responsibilities of knowing how to safely insert and remove my contact lenses. If I do not know or do not remember how to safely insert & remove contact lenses and clean my contact lenses, I will take the responsibility to have the entity selling me the contact lenses properly teach me. I assume all responsibilities of damage and harm for **not** using the proper contact lens and contact lens care system prescribed by my eye doctor. Remember, the Federal Drug Administration (FDA) classifies contact lenses as medical devices. Furthermore, I will allow my doctor to use pertinent personal information to order my contact lens as needed.

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Please answer the following questions as best as you can. Since various medical conditions affect the health of the eye, your answers will help us to provide a more thorough eye exam.

What is your reason for today's visit:____

(Check all that apply) ___ Blurry at Distance ___ Blurry at Near ___ Blurry at Computer ___ See Spots/Floaters

___ See "Flashes" ___ Eyes Itch ___ Eyes Burn or Dryness

When: Last Eye Exam: ________ Eye Doctor: ________________ Last Physical Exam: __________ Doctor: ______________

Please check any conditions that apply to you or family member or Check □ **No Change** of info. below.

EYE CONDITIONS		**MEDICAL CONDITIONS**	
Cataracts	___Me ___Family	Diabetes	___Me ___Family
Glaucoma	___Me ___Family	High Blood Pressure	___Me ___Family
Macular Degeneration	___Me ___Family	Heart/Blood Disease	___Me ___Family
Eye Surgery	___Me ___Family For?_____________	Breathing Problem	___Me ___Family
Eye Injury/Trauma	___Me ___Family	Cancer	___Me ___Family
Eye Disease	___Me ___Family Name?___________	Headaches	___Me ___Family
Eye Infection	___Me ___Family Is it reoccurring? Y or N	Herpes	___Me ___Family
Lazy Eye (eye turn/amblyopia)	___Me ___Family	HIV/AIDS	___Me ___Family
Double Vision	___Me ___Family	Thyroid	___Me ___Family
Color Vision Problem	___Me ___Family	Multiple Sclerosis	___Me ___Family
Depth Perception Problem	___Me ___Family	Arthritis	___Me ___Family

Other Eye Conditions/Disease:_____________________________ Other Medical Conditions:_____________________

List all medications you are currently taking or attach a list:____

____

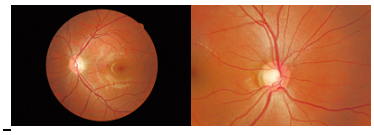
List all allergies / allergies to medications you have:____

>>>>>>>>**PLEASE CONTINUE ON BACK PAGE AND THEN SIGN**<<<<<<<<<<<

PATIENT CONSENT FORM

(1) Digital Retinal/ Fundus Photography (Additional ~~$60~~ $35 Introductory Price): Our office offers digital retinal imaging, which uses a computer-integrated digital imaging system to record a detailed view of the retina. Since nothing touches the eye, photo-documentation is painless. This digital image provides an excellent reference point for future comparisons. Retinal photography assists in the detection and management of problems such as diabetic changes, hypertensive retinopathy, macular degeneration, optic nerve disease, and retinal holes or thinning. Retinal images can be taken on dilated and un-dilated eyes. Photo documentation of the retina is strongly recommended for patients with retinal conditions but is optional for patients when performed as preventative care. ** ***The doctor strongly recommends having your eyes dilated or taking Retinal Photos for a thorough eye exam, especially if it is your first eye exam.*** ** **This enables the doctor to evaluate the inner health of your eye.**

Dilation drops last on average about 2 to 4 hours. It temporarily impairs near vision, increases light sensitivity, and in most cases, does not greatly decrease distance vision, but you may need to pay extra attention if you drive afterwards.



PLEASE CHECK ONE:

___ I'd like dilation now **(Additional $30 for dilation only):**
___ I refuse dilation (And I agree to assume all risks associated with failure to diagnose my eye condition due to lack of information, which may have been provided by this test.)
___ I wish to have retinal photographs taken instead of Dilation **(Recommended)**

(2) Analytical Visual Field Screening (Additional $30): consists of computerized screening of your field of vision to detect any significant (or even early) signs of defects (such as neural abnormality, glaucoma, tumors, and etc.) along the visual pathway to the brain. **This enables the doctor to evaluate the nerve signals from your eye to your brain.**

PLEASE CHECK ONE:

___ I'd like visual field screening now.
___ I refuse visual field screening (And I agree to assume all risks associated with failure to diagnose my eye condition due to lack of information, which may have been provided by this test.)

>> IF NOT FILING INSURANCE, THEN SKIP THIS SECTION and Go To Signature <<

Your insurance company must authorize all coverage before testing can begin; otherwise the doctor will not be able to directly take your insurance. Patient may file on his/her own. Most insurance does not cover additional fees:

- **Vision Insurance Name** (for Glasses/Contact Lens prescription)**:** _____

  or Medical Insurance Name (for all other exams)**:**_____
- **Primary Insurer's Name:** _____

  & Birth Date: _____ **Social Security #:** _____ **Phone #:** _____
- If applicable**, Member's ID #:**

I authorize payment directly to my doctor or clinic, the use of my patient files for the use of insurance submissions, and the release of information to all my insurance carriers. **I understand that if there is any problem with the insurance claim, I am directly responsible for charges incurred by the dependent and/or myself.** I understand each insurance carrier may have different acceptable fee schedule codes for each type of exam; thus, my exam will be coded with the acceptable fee schedule to be reimbursed.

****Payment is due when professional services are rendered and are non-refundable****

I have agreed to all conditions on both pages and authorize examination and treatment (sign below)

Patient/Parent/Guardian Signature:_____Date:_____