**Oasis Vision PLLC**

**Komal V. Shanmugam, O.D.**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **PATIENT INFORMATION** | | | | | | | | | |
| Last Name First Middle | | | Birth Date: | | | | Guardian’s Name: | | |
| Street Address | | Home phone # | | | | Cell phone # | | | Sex:  ❑ M ❑ F |
| City | State | Zip Code | | | Email | | | | |
| Occupation | Employer | | | Office Phone # | | | | Ethnicity/Race | |
| Reason for today’s visit | | | | | | | | | |
| ❑ Regular check-up ❑Glasses ❑ New Contact Lenses ❑ Emergency ❑ Other | | | | | | | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Personal and Family Eye History**  **Last vision examination:\_\_\_\_\_\_\_\_\_\_\_\_\_\_**    **Do you wear Glasses? Y N Contacts? Y N**  What type of CL? ❑soft ❑hard ❑sphere ❑toric ❑mono/multifocal  How often do you replace them? ❑daily ❑2 weeks ❑monthly  **Have you had any of the following?**  Eye injury Yes No  Eye surgery Yes No  Eye disease Yes No  Glaucoma Yes No  Cataracts Yes No  Sudden vision loss Yes No  Macular degeneration Yes No  **Do you frequently experience (circle)?**  Eye Strain Nausea Loss of place reading  Blur far away Night Vision loss Burning, Itching  Blur up close Light Sensitivity Fatigue with reading  Double vision Redness of eyes Dryness  Squinting Pain in/around eyes Excess tearing  Dizziness Color vision problems Mucus Discharge  **Any family members with eye disease? Whom and what type?** | | **Personal and Family Health History**  List any medications you are taking? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Are you allergic to any medications? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Are you Pregnant? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Do you drink Alcohol? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tobacco/how much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other Substances?\_\_\_\_\_\_\_\_\_\_  **Please indicate if you, or an immediate family member, have ever had (check X):**  You Family Who?  Diabetes \_\_\_\_ \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_  High Blood Pressure \_\_\_\_ \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_  Heart Disease \_\_\_\_ \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_  Arthritis \_\_\_\_ \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_  Asthma \_\_\_\_ \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_  Allergies \_\_\_\_ \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_  History of Headaches or Migraines \_\_\_\_ \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_  Chronic Diarrhea or Constipation \_\_\_\_ \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_  Kidney Disease \_\_\_\_ \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_  Cancer \_\_\_\_ \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_  Thyroid Disease \_\_\_\_ \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_  Anemia or Bleeding Problems \_\_\_\_ \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_  Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **INSURANCE** | | | | |
| Insurance Company: | Member ID Number: | | SSN: |  |
| Subscriber Name: | Subscriber DOB: | | Relationship to subscriber:  ❑Self ❑ Spouse ❑ Dependent |  |

|  |
| --- |
| **Dilation** of the eyes allows us better evaluate the internal health of your eyes and **it is recommended.** The drops will enlarge the pupils so that we can get a better look inside; however, the drops will cause you to have **blurred near** vision and be **sensitive to light** for 2-3 hours. **There is a $20 additional charge for this test. Would you like this test?** ❑ Yes ❑ No, I decline the dilation ❑ I would like to discuss with the doctor  I have been informed by *Oasis Vision PLLC* (from the above or verbal explanations) of the importance of pupil dilation. If I have not indicated a clear choice, or made a no choice regarding the test, this will be the same as a “NO” answer to the above questions. If I have chosen not to have the test performed, or any other recommended test or referral, or I have given incomplete or inaccurate information, I will not hold *Oasis Vision PLLC* responsible for any diseases or pathology that goes undetected due to the lack of diagnostic information that could have been obtained by these testing procedures. |
| **Follow-up Care/Insurance Claims**  I understand that pertinent, with restrictions, follow-up appointments up to **60 days for glasses and 30 days for contact lenses** are included in the exam fees. **Office fee(s) will be charged after these time periods have expired.**  The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize *Oasis Vision PLLC* or insurance company to release any information required to process my claims. |
| **HIPAA**  My signature below also indicates I have been informed of my rights under the HIPAA Privacy Policies. |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient/Legal Guardian Date