**Oasis Vision PLLC**

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

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| **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 |

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| **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/multifocalHow often do you replace them? ❑daily ❑2 weeks ❑monthly**Have you had any of the following?**Eye injury Yes NoEye surgery Yes NoEye disease Yes NoGlaucoma Yes NoCataracts Yes NoSudden vision loss Yes NoMacular degeneration Yes No**Do you frequently experience (circle)?**Eye Strain Nausea Loss of place readingBlur far away Night Vision loss Burning, ItchingBlur up close Light Sensitivity Fatigue with readingDouble vision Redness of eyes DrynessSquinting Pain in/around eyes Excess tearingDizziness 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 |  |

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| **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.  |

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Patient/Legal Guardian Date