 **Chad L. Rigtrup, O.D.**

**Frank A. Siddoway, O.D.**

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**PERSONAL INFORMATION:**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip Code:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gender: Male Female Would you like us to communicate thru text messaging? Yes No

Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_@\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Eye Examination:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Where:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Emergency Contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical Doctor:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Exam:\_\_\_\_\_\_\_\_\_\_\_\_ Prefered Language:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ethnicity: Hispanic or Latino Native Hawaiian/Other Pac. Island Not Hispanic or Latino Decline to Specify

Race: American Indian / Alaska Nat. Asian Black/A. American Hispanic White Other:\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you Hear about our office?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL INSURANCE INFORMATION: VISION INSURANCE:**

*Primary Medical Insurance*:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Holder:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthday:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SS#/Policy#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS# (last 4):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History:**

Do you have any Drug Allergies? Yes No If yes Explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List *any* Medications you take, including eye drops and over the counter medications:

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

List *any* Surgeries you have had, and/or hospitalizations, including but not limited to eye surgeries:

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

Please check any of the following that you currently have, or are being treated for:

Disease/Condition Yes No Disease/Condition Yes No Disease/Condition Yes No

High Blood Pressure Diabetes Thyroid Disorder

Heart Disease Cholesterol Other

Are you Pregnant or Nursing? Yes No If Pregnant, how many weeks?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Ocular History:**

Do you wear glasses? Yes No  *If yes, how often*: Full Time Driving only Reading Computer

Do you wear Contact Lenses? Yes No *If yes, what brand*:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long do you wear one pair of Contacts before replacement:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Are they Comfortable? Y N

*Note any of the following that you currently have, or have had:*

**Disease/Condition Yes No Disease/Condition Yes No Disease/Condition Yes No**

Glaucoma Crossed Eyes Eye Infection

Floaters Double Vision Cataracts

Iritis Dry Eyes Eye Injury

Droopy Eyelid Retinal Detachment Macular Degeneration

Amblyopia Flashes of Light Blindness

Other (please explain):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social History:** *(this information will be kept strictly confidential)*

Do you drive? Y N Marital Status: Married Divorced Single Widowed

Do you use tobacco products? Yes No If yes, type/amount/how long:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink alcohol? Yes No If yes, type/amount/how long:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use illegal drugs? Yes No If yes, type/amount/how long:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been infected with or exposed to: HIV Hepatitis Gonorrhea Syphilis None

**Review of Symptoms:**

Do you currently, or have you had any problems in the following areas:

**System Yes No System Yes No**

Constitutional (fever, weight loss/gain) Musculoskeletal (arthritis, muscles, bones)

Integumentary (skin) Ears, nose, mouth, throat

Neurological (headaches, numbness) Cardiovascular/Vascular (heart)

Psychiatric (mental, depression, anxiety) Respiratory (lungs)

Endocrine (diabetes, thyroid) Gastrointestinal (stomach, live, intestines)

Lymphatic, Hematologic (blood, lymph) Genitourinary (kidneys, urinary)

Other problems, not listed above:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History:**

Please note any family history (parents, grandparents (maternal or paternal), siblings, children) with the following:

**Disease/Condition Yes No Relationship Disease/Condition Yes No Relationship**

High blood pressure \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Retinal Detachment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diabetes (type 1) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Diabetes (type 2) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Crossed/Lazy Eye \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Glaucoma \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Macular Deg. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cataratcts \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any other history of eye conditions not listed above:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- |
| **Why have my eyes dilated?**   * Having your eyes dilated is an essential part of a routine eye examination. This procedure helps the doctor to get a better view of your retina, and other important structures in the back of your eye. Without dilation the doctor’s view of these structures is limited, and sometimes difficult to see. Often times things can be missed, that otherwise could be easily diagnosed during a dilated fundus exam. There are certain conditions that require dilation, and if you have one of these conditions, the doctor will further discuss the importance of dilation for you. |
| **What are the side effects?**   * Having your eyes dilated requires the doctor to put a couple of drops into your eyes. These drops relax certain muscles and allow your pupils to get larger. Some of the ***side effects*** of these drops include: ***light sensitivity, blurry vision (especially near)***, and occasionally ***headaches***. These side effects can be expected to last anywhere from 3 – 6 hours. |
| **How much does it cost?**   * There are no additional charges for having your eyes dilated today, please select one of the following:   **Yes, I consent to have my eyes dilated today**  **No, I do not want my eye’s dilated today.‬** |

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| --- |
| **Informed Consent**   * Payment for all medical services is the responsibility of the patient, and is expected at the time of service, including, but not limited to insurance co-pays. * I agree to pay all attorney fees, court fees, including charges or commissions up to 50% that may be assessed to me by any collection agency retained to pursue this matter. I further agree to pay interest at the rate of 1 ½ % per month (18% per year). I understand there is a $15.00 service charge for all returned checks. * I hereby authorize the release of medical information concerning my illness and treatment by this clinic to my insurance company, and the Health Care Financing Administrations or its agents. I also authorize release of my personal medical information to any doctor to whom I may be referred for a consultation. I authorize payment of medical benefits to provider or facility. I understand that any other information about me including prescriptions for glasses or contact lenses, will not be release to anyone else without my written consent. * I hereby authorize any procedures as may be deemed necessary for my care. I also grant permission for treatment if this patient is a minor.   **Signature of patient or legal guardian:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |