Indigo Vision Center

Dr. Owen Johnson

Last Name: _____

First Name: _____ Nickname: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Daytime Phone (if different): _____

Cell Phone: _____ May we text you: Y N

E-Mail Address: _____

Referred By: _____

Sex: M F Date of Birth: _____

Social Security Number: _____

Marital Status: _____

Employment Status: _____

Employer: _____ Occupation: _____

Preferred Language: _____

Race:

- Native American/Native Alaskan ☐
- Asian ☐
- Black/African American ☐
- Hispanic ☐
- Native Hawaiian/Other Pacific Island ☐
- White ☐

Ethnicity:

- Hispanic/Latino ☐
- Native Hawaiian/Other Pacific Island ☐
- Not Hispanic/Latino ☐

Communication Preferred: Email Telephone Postal

Last Eye Exam: _____ Doctor: _____

Reason for today's visit: _____

_____

PATIENT HEALTH HISTORY

Patient Name: _____ DOB: _____

Primary Care Physician: _____ Date Last Seen: _____

Medical/Family History (use back sheet if more space is needed)

Please list all your current medications (include over the counter, vitamins and herbal therapy):_____

_____

_____

List all major surgeries (Eye Surgery included):_____

_____

List any allergic reactions to medications or eye drops: _____

_____

Please indicate if any of the conditions apply to you or a family member (blood relatives only).

Disease/Condition	Yourself Yes	Yourself No
Cataract	☐	☐
Eye Turn	☐	☐
Glaucoma	☐	☐
Macular Degeneration	☐	☐
Retinal Detachment	☐	☐

	Yes	No
Women- Are you pregnant?	☐	☐
Are you breast feeding?	☐	☐

	Family Member Yes	Family Member No
Blindness	☐	☐
Eye Turn	☐	☐
Glaucoma	☐	☐
Macular Degeneration	☐	☐
Retinal Detachment	☐	☐

Relationship (Blood Relatives Only)

_____
_____
_____
_____
_____

Other: _____

Review of Systems: Please indicate below if you have or ever had problems with the following conditions:

Allergic/Immunologic
- ☐ None
- ☐ Lupus (SLE)
- ☐ Rheumatoid Arthritis
- ☐ Environmental Allergies
- ☐ Seasonal Allergies
- ☐ Other (i.e., Latex)

Ear, Nose and Throat
- ☐ None
- ☐ Sinusitis
- ☐ Upper Respiratory Tract Infection
- ☐ Other

Gastrointestinal
- ☐ None
- ☐ Crohn's Disease
- ☐ Colitis
- ☐ Acid Reflux/Ulcer
- ☐ Other

Skin/Integumentary
- ☐ None
- ☐ Eczema
- ☐ Rosacea
- ☐ Psoriasis
- ☐ Other

Psychiatric
- ☐ None
- ☐ Depression
- ☐ Bi-Polar
- ☐ Schizophrenia
- ☐ Other

Cardiovascular
- ☐ None
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Stroke
- ☐ Vascular Disease
- ☐ High Blood Cholesterol

Endocrine/Glands
- ☐ None
- ☐ Diabetes
- ☐ Hormone Dysfunction
- ☐ Thyroid Dysfunction
- ☐ Other

Respiratory
- ☐ None
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Other

Muscle/Skeletal
- ☐ None
- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Ankylosing Spondylitis
- ☐ Other

Genital/Urinary
- ☐ None
- ☐ Urinary Tract Infection
- ☐ HIV Positive
- ☐ Herpes/Chlamydia
- ☐ Other

Hematologic/Lymphatic
- ☐ None
- ☐ Anemia
- ☐ Leukemia
- ☐ Bleeding Disorder
- ☐ Other

Neurological
- ☐ None
- ☐ Multiple Sclerosis
- ☐ Epilepsy
- ☐ Tremors
- ☐ Other

General Health
- ☐ None
- ☐ Weight loss/gain
- ☐ Fever
- ☐ Fatigue
- ☐ Trauma

Social
- ☐ Tobacco Use: Current Smoker Former Smoker
- ☐ Non-Prescription Drugs_____
- ☐ Alcohol Consumption_____
- ☐ Weight_____ Height_____

Please sign below to acknowledge that this form is current:

Signature: _____ Date: _____ Reviewed by Doctor's initials: _____

Acknowledgement of Receipt of Notice of Privacy Practices

Name of Patient (Print): _____ Date:_____

Signature of Patient/ Pt Representative (if patient is a minor or an adult unable to sign this form):_____

Relationship of Patient Representative to Patient: _____

Vision insurance information: If no changes please check box ☐

Name of insured_____ Relationship to patient_____

Insurance company_____ Insured SSN_____ DOB_____

Insured ID:_____ Group_____

Medical insurance information: If no changes please check box ☐

Name of insured_____ Relationship to patient_____

Insurance company_____ Insured SSN_____ DOB_____

Insured ID_____ Group_____

Retinal photos and dilation

The digital retinal imaging system takes images of the retina (the back of the eye). This procedure assists the doctor in early detection of many disorders, including glaucoma, diabetic retinopathy, macular degeneration, retinal detachment, and other vision threatening conditions. The images will be stored in the computer and compared with images from future exams. This allows the doctor to observe even the smallest amount of change(s) from the previous procedure. The doctor strongly recommends that all patients have this procedure performed. It is especially important for people who have:

1. Family history of glaucoma
2. Family history of diabetes
3. Family history of high blood pressure
4. Family history of macular degeneration
5. New patient
6. Reached the age of 41
7. Headaches
8. See spots of flashes

There is an **additional charge of $30.00** for this procedure. If a medical diagnosis is made by the doctor, medical insurance **may** cover the cost. If not, **you** the patient are responsible for the cost

Please check the appropriate line below and sign at the bottom

_____ I **do** want the procedure performed

_____ I **do not** want the procedure performed

Signed_____ Date_____

Legal informed consent:

It is state law and policy of this practice that every new patient to our clinic be dilated to allow for a complete retinal health examination. Dilation may cause your close up vision to be blurry. Operating an automobile may be difficult and there will be an increase in light sensitivity while outside. The dilation will last for up to four to six hours.

____ **Yes** I want to follow the recommendations of my doctor and have my eyes dilated.
____ I decline to have my eyes dilated and/or for medical reason(s), please list_____
____ I refuse to have my eyes dilated at this time without a valid medical reason. Indigo Vision Center or the doctor will not assume responsibility for undiagnosed retinal anomalies when dilation is refused for non-medical reasons.