Patient Last Name _____ First Name _____ Middle Initial _____

Nick Name _____ SSN (OR LAST 4 DIGITS) _____ Birth Date _____ Gender _____

Ethnicity/Race _____ Marital Status _____ Height _____ Weight _____

Address _____ Cell Number (____) _____

_____ Work Number (____) _____ Ext. _____

City _____ State _____ Zip Code _____ Home Number (____) _____

May we send you text message reminders? Yes ☐ No ☐

Email address* _____

*Your personal email will be used for the purpose of communicating about future appointments and reminders. Your email address will not be disclosed to any other party and you may opt out of future email communication by notifying the front reception desk.

Employer _____ Occupation _____

Spouse Name _____ Parent with patient today: _____

Health Insurance: Aetna ☐ BCBS ☐ Cigna ☐ Medicare ☐ Presbyterian ☐ United ☐ Tricare ☐ Other ☐ _____

Primary person on health insurance plan: Self ☐ Other ☐ (please fill out next two lines) Relationship to patient: _____

Primary member Name _____ Primary Insured SSN (OR LAST 4 DIGITS) _____ Date of Birth _____

Vision Insurance: Cigna Vision ☐ Vision Service Plan ☐ Eyemed ☐ Vision Care Direct ☐ Other ☐ _____

Primary person on vision plan: Self ☐ Other ☐ (please fill out next two lines) UNM or Wells Fargo employees please list banner Id# or employee # for VSP _____

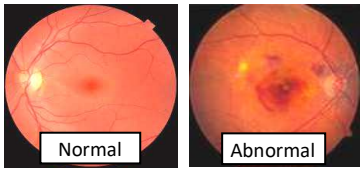
Primary member name _____ Primary Insured SSN (OR LAST 4 DIGITS) _____ Date of Birth _____

Authorization, Release and Acknowledgement

Financial Responsibility: I authorize the release of any information concerning my (or my child's) health care, advice, and treatment provided for the purpose of administering claims for insurance benefits. I acknowledge full financial responsibility for the services provided by Precision Eye Center / Robert L. Lavoie, O.D. and Richard Zobel, O.D. and also hereby authorize my insurance benefits be directly paid to Precision Eye Center. Payment is required at the time services are rendered.

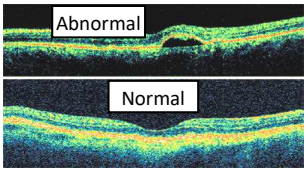
I also understand Precision Eye Center does a FULL COMPREHENSIVE EYE HEALTH AND VISION EXAM, thereby billing my health insurance if there is a medical reason before coordinating my benefits with any other insurance I may have. If I do not want my health insurance billed, it is my responsibility to make Precision Eye Center aware of this. If there is no vision and the health does not cover the services, I am responsible for payment. Precision Eye Center accepts cash, credit/debit cards, and HSA flexible spending account cards. Checks are no longer accepted. I understand that all products are customized for me and that there will be a 15% restocking fee on all returned or cancelled orders. _____ Initial

Health Insurance Portability and Accountability Act: I have been given the HIPAA notice describing how medical information about me may be used and disclosed and how I can get access to this information. I have reviewed it carefully and understand that Precision Eye Center adheres to these guidelines to protect the privacy of my personal health information. _____Initial



To provide thorough eye examinations, Digital Retinal Screening is recommended for all patients at our office. It gives Dr. Lavoie and Dr. Zobel the ability to see many health conditions that could be missed otherwise. Your vision is not affected in any way. With the retinal screening, two pictures are taken of your eyes which are kept on file for comparison to previous and future visits.

The Digital Retinal Screening is $44.00 and is NOT covered by your insurance. _____ **Initial**



Signature of patient or Parent/Guardian: _____ Date: _____

Dilation Consent: Dilation of the eyes is a diagnostic procedure that allows a more thorough assessment of the internal health of the eyes. If you decide to approve dilation, you need to be aware of the following: You will be light sensitive and have trouble with near vision for about 4-8 hours. Your distance vision will most likely be unaffected however you may be more comfortable having someone else drive. There is no additional charge for dilation. If you are diabetic, your insurance may require yearly dilation. Otherwise, we recommend every 2-3 years. Please ask a technician for more information.

Approve dilation ☐ I would like to schedule dilation for another day ☐ Disapprove dilation ☐ signature:_____

Health information Today's date

PRECISION EYE CENTER

Date of last eye exam _____ Last eye Doctor _____

Primary care doctor _____ Address _____ Phone # _____

Please check the self box if you currently have any of the following or have had any genetic testing indicating any of the following conditions. (23andme, ancestry.com, etc.) Please list any immediate family members as well.

Hypertension	Self ☐	Anyone in your family?	Diabetes: type:_____	Self ☐	Anyone in your family?	Blindness	Self ☐	Anyone in your family?
Glaucoma	Self ☐	Anyone in your family?	Cataracts	Self ☐	Anyone in your family?	Corneal Dystrophy	Self ☐	Anyone in your family?
Retinal disease	Self ☐	Anyone in your family?	Retinal detachment	Self ☐	Anyone in your family?	Lazy/Crossed eyes	Self ☐	Anyone in your family?
Lung disease	Self ☐	Anyone in your family?	Macular degeneration	Self ☐	Anyone in your family?	Cancer	Self ☐	Anyone in your family?
Heart disease	Self ☐	Anyone in your family?	Thyroid problems	Self ☐	Anyone in your family?	Vascular disease	Self ☐	Anyone in your family?
Arthritis	Self ☐	Anyone in your family?	Epilepsy	Self ☐	Anyone in your family?	Other health concerns?		

Are you currently taking any medication? Yes ☐ No ☐ Please list _____

Are you allergic to any medication? Yes ☐ No ☐ Please list _____

Do you have any other allergies? (food, seasonal, etc) Yes ☐ No ☐ Please list _____

Have you ever had an eye infection, disease or injury? Yes ☐ No ☐ Please list _____

Are you pregnant? Yes ☐ No ☐ Nursing? Yes ☐ No ☐ Do you smoke? Yes ☐ No ☐ How often? _____ Former Smoker? ☐

Do you experience any of the following eye irritation? Dryness: Yes ☐ No ☐ Pain: Yes ☐ No ☐ Itching: Yes ☐ No ☐

Redness: Yes ☐ No ☐ Tearing: Yes ☐ No ☐ Burning: Yes ☐ No ☐ Swelling: Yes ☐ No ☐

Have you ever seen flashes of light in your vision? Yes ☐ No ☐ How often? Constantly: ☐ Daily ☐ Weekly ☐ Occasionally ☐

Have you ever seen floaters in your vision? Yes ☐ No ☐ How often? Constantly: ☐ Daily ☐ Weekly ☐ Occasionally ☐

Do you have headaches? Yes ☐ No ☐ How often? Daily ☐ Weekly ☐ Monthly ☐ Occasionally ☐ At computer ☐

Have you had Lasik? Yes ☐ No ☐ Cataract surgery? Yes ☐ No☐ Any other form of eye surgery? Yes ☐(type_____)

Vision information

Have you had any changes seeing any of the following?

Computer Monitor: Yes ☐ No ☐ Street Signs: Yes ☐ No ☐ Reading: Yes ☐ No ☐ Fluorescent Lights: Yes ☐ No ☐

Night Vision: Yes ☐ No ☐ Car Headlights: Yes ☐ No ☐ Sports: Yes ☐ No ☐ Haze/Bright Lights: Yes ☐ No ☐

Age of present glasses:_____ Age of sunglasses:_____ Age of computer glasses:_____

How many hours per day do you spend on: Computer_____ Smart Phone_____ TV_____ Driving_____ Digital Entertainment_____

Are you required to wear safety glasses at work? Yes ☐ No ☐

Do you currently wear contacts? Yes ☐ No ☐ Type or Brand _____ What Solution do you use? _____

How often do you replace your contacts? _____ How old are your current contacts? _____

How do your contacts feel by the end of the day? Very comfortable ☐ Mostly okay ☐ A bit scratchy or dry ☐ Down right terrible ☐

New Patient- Would you like to be fit in contact lenses this year? Yes ☐ No ☐ ***Existing Patient***- Would you like to renew your CLs RX? Yes ☐ No ☐

Are you interested in Lasik or any other form of eye surgery? Yes ☐ No ☐

What sports or hobbies do you enjoy? _____