# DRS. HOLCOMB and ASSOCIATES

See well. Live well.

# WELCOME TO OUR OFFICE

## Patient Information Please print.

Name _____ Date _____
First MI Last

Address _____ City _____ State _____ Zip_____

Birth date _____ Sex ◯ Male ◯ Female Social Security # _____

Employer _____ Occupation _____

Contact Info: Home _____ Cell _____ Email _____

**Reason for today's visit** _____

**Responsible Party**? _____ Relationship to patient _____

**Other household members who are patients here** _____

**Please circle best way to notify you of yearly appointments: Email Phone Text**

## Medical History

Last eye exam date _____ Last medical exam date _____ Dr.'s name _____

Check any of the following that apply to you or your family:

| | You | Family | | You | Family | | You |
|---|---|---|---|---|---|---|---|
| Diabetes | ◯ | ◯ | Pregnant | ◯ | | Blur at a distance | ◯ |
| High blood pressure | ◯ | ◯ | Sinus trouble | ◯ | ◯ | Blur when reading | ◯ |
| Heart problems | ◯ | ◯ | Asthma | ◯ | ◯ | Double vision | ◯ |
| Thyroid problems | ◯ | ◯ | Allergies | ◯ | ◯ | Spots/floaters | ◯ |
| Lung problems | ◯ | ◯ | Retinal detachment/disease | ◯ | ◯ | Distorted vision/halos | ◯ |
| Arthritis | ◯ | ◯ | Macular degeneration | ◯ | ◯ | Flashes of light in my eyes | ◯ |
| Cancer | ◯ | ◯ | Eye surgery | ◯ | ◯ | Computer eye strain | ◯ |
| HIV positive | ◯ | ◯ | Cataracts | ◯ | ◯ | Glare bothers me | ◯ |
| Kidney disease | ◯ | ◯ | Glaucoma | ◯ | ◯ | Burning/stinging/itch | ◯ |
| Lupus | ◯ | ◯ | Eye injury | ◯ | ◯ | Dry or Gritty eyes | ◯ |
| Headaches | ◯ | ◯ | Temporary loss of vision | ◯ | ◯ | Tearing | ◯ |
| Migraines | ◯ | ◯ | Blindness | ◯ | ◯ | Mucous discharge | ◯ |
| Seizures | ◯ | ◯ | Crossed or lazy eyes | ◯ | ◯ | Redness | ◯ |
| Vascular disease | ◯ | ◯ | Loss of side vision | ◯ | ◯ | Eye infection | ◯ |

Please list any medications you are taking _____

_____

Please list known allergies (including medicines) _____

Have you ever had your eyes dilated? ◯ yes ◯ no How long ago? _____ Any adverse reaction? _____

Do you currently wear glasses? ◯ All the time ◯ Distance only ◯ Reading/near work ◯ Computer work ◯ Work Safety ◯ Other, please explain _____

**PLEASE TURN THIS SHEET OVER TO COMPLETE THE INFORMATION**

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Have you worn contact lenses? ◯ yes ◯ no Wear them currently? ◯ yes ◯ no If yes, how old are they? _____

Are you interested in wearing contacts? ◯ yes ◯ no

If yes, what style? ◯ Daily Disposable ◯ 2-week ◯ 1-month ◯ Astigmatic (toric) ◯ Multifocal ◯ Colors ◯ RIGID GAS PERMEABLE ◯ Not Sure

Do you work at a computer? ◯ yes ◯ no If yes, how many hours daily? _____

In what hobbies or sports do you participate?_____

Do you need safety eyewear for work/hobbies? ◯ yes ◯ no

## Insurance Information

Insured's Name _____ Relationship to patient _____

Birth date_____/_____/_____ Cell phone #_____ Employer _____

Insured's Address _____

City _____ State _____ Zip _____

Medical Insurance _____ Group # _____ Employer #_____

Vision Insurance _____ Group # _____ Employer #_____

**HOW DID YOU HEAR ABOUT US?** ◯ TV ◯ Radio ◯ Newspaper ◯ Referral ◯ Location ◯ Mail Offer ◯ Previous Patient ◯ Eye Exam Reminder ◯ Online search ◯ Other _____

## Authorization

I authorize the release of any medical information necessary to my family or caregivers, referring or family physicians, or to process a claim on any insurance company. I hereby assign to and authorize directly to Drs. Holcomb and Associates all benefits payable under such an insurance policy. I realize that the insurance benefits may not pay my entire bill, and I agree to pay the difference or the entire bill if necessary.

I agree that Drs. Holcomb and Associates and/or its agents, in order to service my account or collect monies I may owe, may contact me by telephone at any number associated with my account, including wireless telephone numbers which could incur usage charges. I also agree that I may be contacted through text messages or emails, using any email address I provide. Contact methods may include pre- recorded or artificial voice messages and/or use of automatic dialing devices.

I/we have read this disclosure and agree that Drs. Holcomb and Associates, its employees and/or agents may contact me/us as described above.

**X** _____

SIGNATURE OF RESPONSIBLE PARTY DATE

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# AGE-RELATED MACULAR DEGENERATION (AMD) RISK AND SYMPTOM ASSESSMENT

Age-Related Macular Degeneration (AMD) is the leading cause of vision loss among older Americans. It is a progressive condition that causes a part of your retina called the macula to deteriorate with age. The macula is responsible for your central vision, which allows you to do things like read, watch TV, recognize faces and drive.

## Risk Factors for AMD

There are several factors that may increase your risk of developing AMD, including the ones listed below.
Check all that apply:

- ◯ 50 years of age or older
- ◯ Family history of AMD
- ◯ Caucasian (white)
- ◯ Current or past smoker
- ◯ Overweight
- ◯ Heart disease, high blood pressure and/or high cholesterol

Since poor night vision is a common symptom of AMD, we use the AdaptDx ® to measure the number of minutes it takes you to adjust from bright light to darkness. This number is your Rod Intercept™ (RI™) and it can help us detect AMD at its earliest stages. The AdaptDx test is non-invasive and takes 5-10 minutes to complete.

## Early Symptoms of AMD

Before any structural changes can be seen in the back of your eye, you may experience the following early symptoms.
Check all that apply:

- ◯ Difficulty seeing at night
- ◯ Distorted / blurry vision
- ◯ Recent changes in vision
- ◯ Difficulty driving at night
- ◯ Difficulty reading in dim light

Patient Name Patient Signature Date

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# CONTACT LENS POLICY

## Contact lenses are an excellent choice for vision correction!

There is a science to selecting and fitting the best contact lenses based on each patient's history, needs, physiology and preferences.

**INFORMED CONSENT**

I understand that, because contact lenses are placed directly on the surface of the eye, complications may occur even with lenses that fit well. These risks

- include but are not limited to: corneal ulcers, edema, and abrasions and conjunctivitis, both infectious and non-infectious.
- increase for those who sleep in their lenses, do not wear or care for lenses as prescribed, or fail to have periodic evaluations to determine if the lenses continue to be worn safely.

**FEES**

In addition to the annual comprehensive eye exam, the contact lens exam fee also includes the evaluation of best lens options and best fit for your personal needs, as well as progress evaluations, changes or refits for **ninety (90) days**, a starting kit of disinfection solution and storage unit. Fitting fees are nonrefundable.

**FOLLOW-UP CARE**

Progress checks with newly fit lenses are required by licensing boards for optometrists, ophthalmologists and opticians. The initial fit of the lens may alter as the lens material settles on the eye during the first 1-2 weeks of wear. The prescribing physician cannot safely release a final prescription until quality of vision and a healthy corneal/lens relationship has been verified.

**WEAR and CARE**

By signing below, you

- acknowledge that you are comfortable with insertion, removal and care of your contact lenses.
- agree to clean, disinfect and dispose of your lenses according to the care regimen prescribed by your doctor and explained by the dispensing staff.
- agree to discontinue wearing the contact lenses and seek professional help if you notice:
    - Persistent redness, irritation or discomfort
    - Decreased vision while wearing lenses
    - Eye pain and/or light sensitivity

**INFORMATION and INSTRUCTIONS**

Upon satisfactory completion of the fitting process, contact lens prescriptions are **legally valid for one year**.
Monovision patients may experience decreased depth perception when driving.
Please contact our office if you have any further questions or concerns regarding your contact lenses.

_____ _____

Patient or Guardian signature Date

**THANK YOU for selecting us for all your vision and eye-related interests.**
**Our goal is to achieve and maintain satisfying sight for your daily needs**
**with comfortable, convenient and healthy lenses, care regimen and wear-schedule.**

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## OPTOMAP AND DILATED PUPIL EXAMINATION

### Like "having a physical" for your eyes

**The structures that do the seeing are inside your eyes! Without either a laser scan or a dilated examination, your doctor cannot thoroughly assess - nor answer questions related to - the health status of your retinas, optic nerves, and blood vessels.**

People are sometimes surprised by unsuspected and undiagnosed findings of **melanoma, hypertension, diabetes, glaucoma, macular degeneration** when the inside of their eyes are carefully evaluated**.**

Our Doctors request that **all** patients have a digital retinal scan to establish a baseline of their ocular health. These images become part of your health record.

Optomap scans typically do not require dilation. **Dilating your pupils, however, is sometimes necessary to further evaluate internal eye health or to achieve an adequate view of specific ocular structures.**

If your doctor recommends that your eyes be dilated in addition to the retinal scan, please be advised that you **will experience blurred vision when reading and sensitivity to light for about four hours.** We have complimentary "sunglasses". If necessary, dilation can be scheduled for a convenient time within 2 weeks.

If you choose the Optomap Retinal Scan there will be a cost of $39.00 for this service, which may or may not be covered by your insurance plan.

Please check the appropriate box below and sign at the bottom.

**[ ] I would like to follow the doctors' recommendation in having a retinal scan.**

**[ ] I would prefer to be dilated and give permission to be dilated today.**

**[ ] I decline the dilation and retinal scans, acknowledging that I am limiting my doctor's ability to detect and assess my eye health.**

Patient Name _____ Date _____

_____ _____

Patient Signature (or parent/guardian if a minor) Relationship

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## ACKNOWLEDGMENT OF RECEIPT OF PRIVACY STATEMENT

By signing below, I am acknowledging that:

I am either the patient or the patient's personal representative;
I have received a copy of the "Notice of Privacy Practices" for Drs. Holcomb and Associates; and
I understand that I may contact the person named in the Notice if I have questions about the content of the Notice.

_____ _____

Signature of patient or parent/legal guardian/legally responsible person Date

_____

Description of relationship to patient

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### TO BE COMPLETED BY STAFF

**Complete all applicable parts—Please refer to instructions**

*Part 1. Complete if signature requested but not obtained:*
Staff member sought but was unable to obtain an acknowledgment from the patient or the patient's personal representative for the following reason:

◯ Patient/personal representative refused to sign form

◯ Other _____

_____

*Part 2. Complete if patient/personal representative unavailable to sign form on first date of service delivery:*

◯ Form mailed/sent to patient/personal representative on _____.
Date

*Part 3. Complete if either Part 1 or Part 2 completed:*

_____ _____

Signature of staff member Date