COCHRANE FAMILY EYECARE
PATIENT HISTORY QUESTIONNAIRE

Today's Date_____

Last Name_____ First Name_____ MI_____
What name would you like to be addressed by?_____
Date of Birth_____ Birth State _____ SSN_____ - _____ - _____
Primary Language_____ Race/Ethnicity_____/_____ Mother's Maiden Name_____
Home Phone_____ Work Phone_____ Cell Phone_____
Preferred Number (**circle one)** Home / Work / Cell Email Address_____
Address_____ City_____ State_____ Zip_____
Occupation_____ Employer_____
Emergency Contact Name_____ Relationship? _____ Phone _____
Date of Last Eye Exam_____ Dilated? Yes/No Doctor _____
Primary Vision Coverage_____ Secondary Coverage_____
Primary Medical Coverage_____ Secondary Coverage _____

Medical Information

What is your general health?_____
Please note any conditions that apply **(Please circle yes or no.)**
Diabetes Yes/No High blood pressure Yes/No High cholesterol Yes/No
If Diabetic: Type I / II Do you take insulin? Yes/No Year of diagnosis_____
Do you have problems with any of these systems? **(Please circle yes or no.)**

Cardiovascular	Yes/No	Urinary	Yes/No	Psychiatric	Yes/No
Ears/Nose/Throat	Yes/No	Muscles/ Bones	Yes/No	Endocrine (Thyroid)	Yes/No
Respiratory	Yes/No	Skin	Yes/No	Blood/Lymph	Yes/No
Gastrointestinal	Yes/No	Nervous System	Yes/No	Allergic/Immune	Yes/No

Please explain any "yes" answers_____
Allergies to medication? Yes/No Which?_____ Reactions?_____
Other health problems_____
Current medication(s)/vitamins_____
_____
Have you had any operations? Yes/No Kind?_____ Year? _____
Have you ever used cigarettes/tobacco? _____ Currently?_____ Alcohol consumption? _____
Name of family doctor _____
Date of last visit_____ Date of last tetanus shot _____

Family History

High blood pressure Yes/No Relation_____ Macular degeneration Yes/No Relation_____
Diabetes Yes/No Relation _____ Retinal detachment Yes/No Relation _____
Glaucoma Yes/No Relation _____ Cataracts Yes/No Relation _____
*please note whether relation is "paternal" (P) or "maternal" (M) **(Ex. Maternal Grandmother = MGM)**

Personal Eye Information

Have you had any eye operations? Yes/No Type_____ Year?_____
Have you had an eye injury? Yes/No Kind _____
Do you have glaucoma? Yes/No Cataracts? Yes/No Dry eyes? Yes/No
Macular degeneration? Yes/No Retinal detachment? Yes/No Blurred vision? Yes/No
Do you wear glasses? Yes/No Contact lenses? Yes/No ____ Brand/Power _____

**Incomplete items will be assumed to be "negative".*

Cochrane Family Eyecare
Optomap® Retinal Exam and Dilation Consent Form

At Cochrane Family Eyecare, we pride ourselves on providing patients with the best possible standard of care. Because of this, we have always recommended a dilated retinal examination in the past, which allows our doctors to obtain a better view of the retina. As you may know, blurred vision and light sensitivity are common side effects of the dilation process, and after dilation you should not drive or operate heavy equipment unless you feel safe to do so.

We now offer the Optomap® retinal examination. Optomap® is a highly advanced retinal scanner that obtains a wide angle photo of the retina without the side effects of dilation. The picture can help our doctors detect many sight threatening problems such as glaucoma, macular degeneration, diabetes, retinal detachment, and eye tumors. The Optomap® image becomes a permanent part of your medical file, allowing our doctors to compare images in the future. In many cases, there will NOT be a need to dilate after this process. However, some conditions, such as diabetes, may require dilation as well and your doctor will address this individually during your exam. There is an additional fee of $39 for the Optomap® and in most cases it is not covered by insurance.

Patients with epilepsy or seizure disorders are advised not to have the Optomap®procedure done.

In order to fully assess the health of your eyes, our doctors recommend that ALL patients have a thorough examination of their retinas every year with either Optomap® or dilation. Diabetic patients are strongly recommended to elect to have both Optomap® and dilation.

- □ I elect to have the Optomap® retinal exam today ($39.00)
- □ I prefer a dilated retinal exam and understand the side effects (no additional fee)
- □ I elect to have BOTH the Optomap® retinal exam and a dilated retinal exam and understand the side effects ($39.00)

_____ _____

Patient/Parent Signature Date

Cochrane Family Eyecare
3970 S. McCarran Blvd. Ste. 1
Reno, NV 89523
Ph: 775-787-3939 Fax: 775-746-3991

PAYMENT POLICY:

Patients are responsible for all co-pays, deductibles, and the charges for any procedures or services that are not covered by insurance. Any amount not covered by insurance will be paid at the time of service. We accept payment in the form of cash, check, or credit card (VISA, MASTERCARD, AMERICAN EXPRESS, OR DISCOVER as well as CARECREDIT). Patients who do not provide insurance card information or required referral authorizations will be required to pay for all charges at the time of service. Your signature below signifies your understanding and willingness to comply with this policy.

INSURANCE POLICY:

As a courtesy to our patients, we are happy to bill your primary and secondary insurance companies for reimbursement. We will submit claims to your insurance carriers if you have provided us with all pertinent information to process the claim. You are responsible for all deductibles and all charges not covered by your insurance. It is your responsibility to follow up with your insurance when payment has not been made to your physicians or you have questions about your benefits or claims processing.

_____ _____

Signature Date