415 US Hwy 95a S Unit A, Fernley NV 89408
P (775)575-5700 F (775)575-5702
revolutioneyes@att.net

Last Name _____ First _____ Today's Date _____/_____/_____

Address _____ City _____ State _____ Zip _____

DOB ____/____/____ SS#_____/_____/_____ Gender _____ Preferred Phone (_____) _____-_____

Email _____@_____._____ Best way to reach you □ Mail □ Phone □ Email

Reason(s) for visit □ Eye Exam □ First time CL fitting □ Update for current CL □ Medical Problem

How did you hear about our office? _____

Are you planning on getting new: □ Glasses □ Contacts □ Both

Primary Care Physician _____Phone _____

Pharmacy _____ Address (if not in Fernley) _____

Have you or are you currently being treated by an Ophthalmologist? Yes No If yes, who? _____

Please list all Medications (include non-prescription) _____

_____

_____

Do you have any allergies? (Include medications and other) _____

_____

HIPAA Compliance Acknowledgement of Receipt

I acknowledge that according to the Health Insurance Portability & Accountability Act, revolutionEYES is required by law to maintain the privacy of my health information. I have been made aware that a complete list of all HIPAA practices are available to all patients upon request.

Patient, parent or Guardian Signature _____ Date _____

Relationship to the patient _____ Printed name _____

FOR OFFICE USE ONLY - INSURANCE:	**PT ID#**	**Check in/Scanned:**	**PreTest:**
Dilation Y N Optomap Y N Contacts Y N		*Visual Fields Full Limitation Not performed*	

Medical and Ocular History

Have you or any of your blood relatives (***parents, brothers, sisters or children***) been diagnosed with any of these conditions?

Please use **M**=Mom **D**=Dad **B**=Brother **S**=Sister **C**=Child

	Self	Relative	No		Self	Relative	No
Asthma	□		□	Congenital Blindness	□		□
Cancer	□		□	Congenital Color Blindness	□		□
Diabetes Type 1	□		□	Cataracts	□		□
Diabetes Type 2	□		□	Macular Degeneration	□		□
High Blood Pressure	□		□	Glaucoma	□		□
Hyperthyroidism (over active)	□		□	Lazy Eye	□		□
Hypothyroidism (under active)	□		□	Retinal Detachment	□		□
Heart Disease	□		□	Retinal Disorder	□		□
High Cholesterol	□		□	Eye Injury	□		□

	Yes	No	
Do you see double?	□	□	
Frequent headaches?	□	□	
Are you pregnant?	□	□	Weeks _____
Do you smoke?	□	□	
Former smoker	□	□	
Have your eyes been dilated?	□	□	YEAR _____

All exam fees are final (no refunds.) You are entitled to one re-check within 30 days at no charge. All contact lens exams are to be complete within 30 days of the initial exam. After this time there will be a $29 office visit fee. Returned check fee $30.00.

Lifetime Patient Signature: Your signature below is required to bill your insurance company.

I request that payment of authorized Medicare, Medicaid, or other insurance benefits either to me or on my behalf be made to revolutionEYES for any services provided to me. I authorize any holder of medical information about me to release to my insurance company and its agents any information needed to determine these benefits or the benefits payable for related services. I also understand that in the event my insurance does not provide payment to revolutionEYES, I will be held responsible for said charges.

BY SIGNING BELOW, I ACKNOWLEDGE THAT ALL THE INFORMATION LISTED IN MY PATIENT INFORMATION IS CORRECT. FURTHER, I UNDERSTAND THAT ANY PATIENT UNDER THE AGE OF 18 MUST BE ACCOMPANIED BY A PARENT OR LEGAL GUARDIAN. IF SIGNING FOR A MINOR, I ATTEST THAT I HAVE THE LEGAL RIGHT TO DO SO.

Patient/Guardian Signature _____ Date _____