Always Focusing on Katy

281.693.EYES (3937)
1534 S. Grand Pkwy - Katy www.grandvisionkaty.com

Patient Information

Date: ____________________ Date of Last Exam ______________________________

(Circle) Mr. Mrs. Ms. Miss. Dr. Social Security _________________ Email ________________________________

First Name: ______________________ Middle Initial____________ Last Name ________________________________

Address : ___________________________Apt # ________City________________ State__________ZIP_____________

Home Phone : ______________________Work Phone ______________________ Cell Phone ____________________

Sex: ☐ Male ☐ Female Date of Birth ________________ Occupation _______________________

Marital Status ☐Single ☐ Married ☐ Divorced ☐Other ☐ Widowed

Referred By (please √) ☐ School Ad ☐ Magazine Ad ☐ Newspaper ☐ Coupon ☐ Insurance ☐ Walk In

If personally referred who can we thank for the referral? ____________________________________

For patients with insurance; in order to process your insurance claim, ***you must present your insurance card or voucher at the time of service.*** Failure to do so may result in denial of your claim. Please understand that you are financially responsible for all charges, whether or not paid by said insurance. **By signing here you are stating that the primary insurance holder is AWARE of the use of his/her policy.**

Patient/Parent/Guardian Signature: __________________________________ Date: ________________

Computerized Visual Field Testing

Computerized visual field testing can help in the early detection of glaucoma, retinal problems, and some neurological diseases and enables us to better diagnose possible causes of headaches. We recommend that patients receive this procedure annually to ensure the most extensive comprehensive examination available. The cost for the visual fields testing is **$20.00**. Do you want computerized visual field testing today? ☐ Yes ☐ No

Pupil Dilation: (Pupil Enlargement)

Pupil dilation enlarges the size of the pupil which allows the doctor a more thorough examination of your retina. For most individuals, it will blur your near vision for approximately 2-4 hours. Dilation is included in the price of the examination.

Would you like to be dilated today? ☐ Yes ☐ **No** **If No, please sign here :** __________________________

Contact Lenses:

Do you have or ever had contact lenses? ☐ Yes ☐ No Wearing time for today? __________________

Last time worn: _____________________ Contact Lens Type: ___________________________________

Contact Lens Service Agreement

Occasionally, even the most compliant of contact lens wearers will have a problem with their contact lenses. All our contact lens fittings include follow up visit(s) within 90 days of the original examination at no charge. The service agreement will allow you to schedule a progress visit at **NO CHARGE** up to 6 months from the annual exam date. This visit covers complications regarding contact lens prescription or a refit into another contact lens. The service agreement fee is **$20.00**. The fee for a progress visit **WITHOUT** the service agreement starts at $55.00 per visit.

I ACCEPT the service agreement ____ Date __________________________

I DECLINE the service agreement ____Date _________________________

Acknowledgement of Notice of Privacy Practices ('NPP')

I acknowledge that I have received and/or read a copy of Grand Vision Center's notice of Privacy Practices.

Patient/Parent/Guardian Signature: ____ Date: _____________________

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Patient Medical History Questionnaire
Please Answer ALL questions.

First Name ______________________ MI ________ Last Name ______________________

Medical Information

What is your general health? ____________________________

Do you have problems with any of these systems? (Please circle Y –yes, N – no)

Eyes	Y / N	Nervous	Y / N	Gastrointestinal	Y / N
Ears/Nose/Throat	Y / N	Genitourinary	Y / N	Endocrine (glands)	Y / N
Cardiovascular	Y / N	Musculoskeletal	Y / N	Blood Lymph	Y / N
Respiratory	Y / N	Integumentary	Y / N	Allergic /Immunologic	Y/ N

Please Explain ____

Diabetes Y / N Type __________________ Date of Diagnosis ______________

Allergies Y / N If yes, please list: ______________________________

Medication Allergies Y / N If yes, please list medications: ____________________

Other Health Problems? ____

Current Meds	Dosages	Changes in Meds*	Discontinued Meds *
____________	____________	____________	____________
____________	____________	____________	____________
____________	____________	____________	____________
____________	____________	____________	____________
____________	____________	____________	____________

Since last visit to Grand Vision

Have you had any operations? Y / N What type ? _______________ Date _______________

Do you use cigarettes/tobacco Y / N Alcohol? Y / N Other Substances Y / N

Name of Family Doctor ______________________ Date of Last Visit ______________________

Date of last tetanus shot __________ Pregnant? Y / N Nursing? Y / N

Family History

High Blood Pressure	Y / N	Macular Degeneration	Y / N	Diabetes	Y / N
Retinal Detachment	Y / N	Glaucoma	Y / N	Cataracts	Y / N
Other Eye Conditions	Y / N	What type? ______________________			

Personal Eye Information

Reason for visit? ____

Have you had any eye surgery(ies) Y / N What Type? ____________________Date __________

Eye Injury Y / N Recent eye infection Y / N Other Eye Problems Y / N ______________

Place / Date of Last Eye Examination ____________________________

Do you have ………..

Glaucoma	Y / N	Cataracts	Y / N	"Lazy Eye"	Y / N
Sinus Problems	Y / N	Headaches	Y / N	Light Flashes	Y / N
Floaters	Y / N				

Do you wear glasses Y / N what type? __________ Contact Lenses Y / N Wearing Time Today ______

Patient/Parent/Guardian Signature ______________________ Date __________

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Optomap™

Our office is proud to provide our patients with the most highly advanced digital Retinal imaging technology available today! Our ability to view your internal Retinal health is now dramatically improved with the Optomap.

Your doctor is concerned about retinal problems such as macular degeneration, Glaucoma, retinal holes, retinal detachments, and diabetic retinopathy (All of which can lead to partial loss of vision or blindness).

EARLY DETECTION IS CRUCIAL!

The Optomap provides:

- A digital computerized map of the retina.
- An in depth view of the retinal layers where disease can start.
- The ability to show you your images today during your exam.
- A permanent record for your medical files (year to year screenings for potential eye disease, and tracking of diagnosed eye disease).

Because your insurance is designed to only cover a basic eye exam, it does not cover advanced screening tools such as the Optomap. The doctors strongly recommend that ALL patients have an Optomap annually. The additional fee is only $39. ***For most patients, the digital imaging can be used in lieu of a dilated eye examination, this will eliminate the need to use dilation drops.***

__Yes - I want this new technology w/photos

__ No - I decline

Patient Signature Date ______________________________ Date ___________