Optical Expressions

Date_____/_____/_____

Patient Profile		
Legal First Name:		**Nickname:**
Middle Initial:	**Last Name:**	
Home		
Address:		
City:	**State:**	**Zip:**
Other Information		
DOB:	**SS#**	
Do we see members of your family household? No/Yes Please List their names:		

Sex, race and ethnicity questions are asked for genetic ethic health purposes:							
Sex:	**Male**	**Female**	**Trans-male**	**Trans-female**	**Genderqueer**	**Unknown**	**Choose not to answer**
Race:	Asian		African American/Black	Pacific Islander	Caucasion/White	Unknown or Other:	
Ethnicities:	Hispanic/Latino			Not Hispanic/Latino		Decline Race & Ethnicities	

Phone and Email		
What is your preferred contact method?		
Home:	**Work:**	**Cell:**
Pager:	**Email:**	

Additional Information					
Marital Status:	Single	Married	Other:		
Previous Names:					
Drivers License #:					
Employment:	Full Time	Part Time	Other:		
	Student	Retired	Homemaker	Military	disAbled
Employer:			Occupation:		

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Referral Information:			
Another Patient: They will get a thank you from us!			
Facebook	**Insurance**	**Google**	**Website:**
Other:			

PHR:		
Would you like access to your online records?	**Yes**	**No**
Emergency Contact Name:	**Number:**	

Insurance				
Are you the primary on insurance:		**Yes**		**No**
If no: What is the legal name of primary insured :			**Last 4 of Primary Social:**	**Primary DOB:**
Relationship to Primary:	**Spouse**	**Parent**	**Other:**	**Self**
Primary Employer: This helps us find your Vision Ins.				
Health/Medical Ins. :				
ID# :		**Group #:**		
Vision Insurance :	○**Advantica** ○**Always Vision** ○**Davis** ○**Health Scope** ○**Envolve** ○**Eyemed** ○**NVA** ○**Spectra** ○**Superior** ○**UHC** ○**VSP** ○**VBA** ○**Eyequest** ○**Humana** **Other:**_____			
ID# :		**Group #:**		

Optical Expressions is proud to provide the latest in retinal imaging.
The OPTOMAP IS OBTAINED ANNUALLY FOR ALL EXAMS

We now provide imaging of the retina on all patients with a new scanning digital system called Optomap. Prior to Optomap the way to thoroughly examine the retina was dilaton. *The optomap only takes a few seconds to perform and is done without dilation. It provides a permanent, digital image of the inner layers of your eye, which your doctor will be able to review with you in the exam room today.* Many eye conditions such as glaucoma, macular degeneration, diabetic retinopathy, melanoma or other tumors are painless and have no symptoms in their early stages. This invaluable tool will help us more easily detect and monitor many disease processes of the eyes.

EARLY DETECTION OF EYE DISEASE IS CRUCIAL!

The test is sometimes covered by insurance, but if not it will cost $19.

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SIGNATURE ON FILE

- ❑ I authorize the use of this form on all of my insurance submissions.
- ❑ I authorize the release of information to all of my insurance carriers.
- ❑ I understand that I am responsible for my bill.
- ❑ I authorize my doctor to act as my agent in helping me obtain payment from my insurance carriers.
- ❑ I authorize payment directly to my doctor.
- ❑ I permit a copy of this authorization to be used in place of the original.
- ❑ I authorize this document as my HIPPA form, I understand I can request a detailed HIPPA at any point from Optical Expressions. You may also view the Hippa compliance on our website under forms.

Date _____ Print Name/Guardian _____

Signature/Guardian _____

Patient Name (if not self): _____

QUANTIFEYE

MACULAR DEGENERATION RISK FACTORS			
About *YOURSELF*	**Yes**	**About your FAMILY**	**Yes**
Age: 30 & over			
Sensitive to light			
Female			
Excessive exposure to the sun		Macular Degeneration	
Light eyes, light skin		Glaucoma	
Inadequate intake of green, leafy veg		Cataract	
Smoker Yes-if you quit/or social/2nd hand		High Blood Pressure	
Glaucoma		Diabetes	
High Blood Pressure		Heart Disease	
Diabetes			
Heart Disease			
Cataract			
PERSONAL TOTAL		**+ FAMILY TOTAL**	

To our Patients,
We continuously strive to provide our patients the very best in eye care services. This device allows us to assess your risk of developing an eye disease called Macular Degeneration. This disease is a leading cause of blindness in adults and there is no adequate treatment; however, it may be managed if caught early. We can now take measures to reduce your risk of developing this disease.
The test is a light response test that only takes a few minutes. We strongly recommend that you take this test so we can assess your risk for Macular Degeneration and develop a base-line measurement that allows us to track any changes that might occur in the future. Since this is a new test, it is not covered by your insurance; however the cost to you is a minimal charge of $20.00
Optical Expressions,
Thomas Cullinane, OD, Judie Miles, OD,
Dr. George Dowdy, OD,
Julie Emming, OD, Jeffery Weaver, OD
I understand my risk factors for Macular Degeneration and choose to:
◯ **Accept Test** ◯ **Decline Test**
Initial:_____

For Office use only:Personal+Family= _____ ◯ High ◯ Medium ◯ Low MPOD Score_____ R/L <.25 .25-.45 > .45

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FAMILY HEALTH HISTORY-mark any updates since we last saw you:									
Cancer	Yes	No	***Relationship:***	Father	Mother	Bro.	Sis.	Son	Daughter
Diabetes/Type:__ –	Yes	No	***Relationship:***	Father	Mother	Bro.	Sis.	Son	Daughter
Hypo/HyperThyro	Yes	No	***Relationship:***	Father	Mother	Bro.	Sis.	Son	Daughter
Hypertension	Yes	No	***Relationship:***	Father	Mother	Bro.	Sis.	Son	Daughter
OCULAR FAMILY HISTORY									
Macular Degeneration	Yes	No	***Relationship:***	Father	Mother	Bro.	Sis.	Son	Daughter
Cataract	Yes	No	***Relationship:***	Father	Mother	Bro.	Sis.	Son	Daughter
Glaucoma	Yes	No	***Relationship:***	Father	Mother	Bro.	Sis.	Son	Daughter
Retinal Detachment	Yes	No	***Relationship:***	Father	Mother	Bro.	Sis.	Son	Daughter

REVIEW OF SYSTEMS			
Yes	**Condition Type**	**Yes**	
Constitution:		***Genitourinary/ GU***	
	Developmental disAbilities		Kidney Disease
	Cancer		Prostate Disease/Cancer
	Fatigue Syndrome		STD: Type:_____
Other:			Benign Prostate Hypertrophy
ENT:			Pregnant
	Hearing Loss		Nursing
	Sinusitis		Herpes
	Dry Mouth	Other:	
	Laryngitis	***Muscular Skelton***	
Other:			Osteoarthritis
Neurological:			Fibromyalgia
	Multiple Sclerosis		Muscular Dystrophy
	Epilepsy		Ankylosing Spondylitis
	Cerebral Palsy		Osteoporosis
	Tumor		Gout
	Stroke/CVA	Other:	

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	Migraine	***Integument or Skin***	
	Autism Spectrum		Eczema
Other:			Rosacea
***Psychological*:**			Psoriasis
	Depression		Cold Sore
	Attention Deficit		Shingles
	Anxiety Disorder	Other:	
	Bipolar	***Endo/ Internal***	
Other:			Diabetes Type:
Cardiovascular:			Diagnosis/ Onset Date:
	Hypertension/High Blood Pressure		Thyroid Dysfunction
	Stroke/CVA		Hormonal Dysfunction
	Heart Disease	Other:	
	Congestive Heart Failure	***Hemoglobin/ Lymphatic System***	
Other:			Anemia
Respiratory:			Large Volume Blood Loss
	Cigarette Smoker: Social/Past /Current or 2nd hand		Ulcer
	Asthma		Hypercholesterolemia/ High Cholesterol
	Bronchitis	Other:	
	Emphysema	***Immune System***	
	Chronic Obstruction		Rheumatoid Arthritis
	Sleep Apnea		Lupus
Other:			Sjogren's Syndrome
***Gastrointestinal* /GI**			Covid-19
	Crohns	Other	
	Ulcer	**Anything else medically you would like to make us aware:**	
	Acid Reflux		
	Celiac Disease		
Other			

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Medications and Allergies			
Medications:	***Dosage:***	***Allergies:*** *Medical and Environmental*	***Reaction:***
		Are you allergic to Latex:	

Medical Notes							
Do you wear contacts?	Yes	No	***If Yes:***	Daily	2 week	Monthly	Other:
Contact Lens Brand-Type:							
Are you interested in Lasik?			Yes		No	Maybe-Tell me more	
Height:			**Weight**:			**Overall Health:**	
Primary Care Provider/PCP First Last and Practice List Below:							
PCP Address:							
PCP Phone:				PCP Fax:			
Preferred Pharmacy							
Pharmacy Name:						Pharmacy #:	
Pharmacy Fax:				Cross Street/address:			
Or Adress:							

For yourself -EYE CONDITIONS OR PROBLEMS:								
Eye operations:						**Date:**		
Eye injuries:						**Date:**		
MacDegeneration	Yes	No	**Glaucoma**	Yes	No	**Do you wear contacts?**	Yes	No
Blurred Vision	Yes	No	**Cataracts**	Yes	No	**Contact Brand:**		
Retinal Detach	Yes	No	**Wear gls?**	Yes	No	**Type:**		
Alcohol	Yes	No	**Frequency:**			**Power Reye:**		
Illiagal Drugs	Yes	No	**Frequency:**			**Power Leye:**		
Smoking Status:						**B.C./DIA:**		
	Current everyday smoker					Some days smoker		

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	Former smoker		Heavy tobacco smoker

SPEED

For the Standardized Patient Evaluation of Eye Dryness (SPEED) Questionnaire, please answer the following questions by checking the box that best represents your answer. Select only one answer per question.

Report the type of ***SYMPTOMS*** you experience and when they occur:	At Visit		Within last 72 hrs		Within last 3 months	
Symptoms	Yes	No	Yes	No	Yes	No
Dryness, Grittiness or Scratchiness						
Soreness or Irritation						
Burning or Watering						
Eye Fatigue						

Report the ***FREQUENCY*** of your Symptoms using the rating listed below:

0 = Never
1 = Sometimes
2 = Often
3 = Constant
4 = Intolerable

Symptoms	0	1	2	3	4
Dryness, Grittiness or Scratchiness					
Soreness or Irritation					
Burning or Watering					
Eye Fatigue					

Report the ***SEVERITY*** of your symptoms using the rating list below:

0 = No Problems
1 = Tolerable-not perfect, but comfortable
2 = Uncomfortable-Irritating, but doesn't interfere with day
3 = Bothersome-Irritating and interferes with day
4 = Intolerable-unable to perform daily tasks

Symptoms	0	1	2	3	4
Dryness, Grittiness or Scratchiness					
Soreness or Irritation					
Burning or Watering					
Eye Fatigue					

Do you use eye drops for lubrication? ▢ No ▢ Yes, Type:_____

And how often? _____

Office use:Total SPEED Score: (Frequency + Severity=_____ /28)

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