Weston Family Eyecare

Dr. Jane M. Therrien
Board Certified Optometric Physician

Patient Information:

Patient's Name _____ Date _____

Parent or Guardian _____ Patient's Birthdate _____
(If patient is a minor)

Mailing Address _____ Home Phone # (____)_____
Cell Phone # (____)_____
_____ Work Phone # (____)_____
(City) (State) (Zip Code)

E-mail address _____ Occupation _____

Employer or School (if patient is a student)_____ Grade _____

SS # _____
(if using insurance)

How did you find out about our office? _____

My visit today is for (circle one): glasses contact lenses laser vision correction office visit
Other (please explain)_____
Are you considering new glasses? Yes/No Contacts Yes/No Sunglasses Yes/No

Date of last eye examination: _____ Doctor: _____

Social History: This information is kept strictly confidential. However you may discuss it directly with the doctor if you prefer.

Do you drive? Yes No If yes, do you have visual difficulty when driving? Yes No

Do you use tobacco products? Yes No If yes, type/amount/how long: _____

Do you drink alcohol? Yes No If yes, type/amount/how long: _____

Do you use illegal drugs? Yes No If yes, type/amount/how long: _____

Have you ever been exposed to or infected with any sexually transmitted disease? Yes No
If yes, please give details:
_____

Medical History:

Are you pregnant and/or nursing at this time? Yes No

List any health problems: _____

_____

_____

Are you taking any medications (including eye drops and over-the counter) and what for? Yes No

_____

_____

Are you allergic to any medications? Yes No

(if so, please list) _____

Eye History:

Eye injuries Yes No
(foreign objects, black eye, etc.)
Eye disease Yes No
(cataract, glaucoma, macular degeneration, etc.)
Eye surgery Yes No
(cataract, laser vision correction, etc.)
If yes to any of the above, please tell what and when:

_____

_____

_____

Do you wear contacts? Yes No

If so, type _____

Review of Systems:
Do you currently, or have you ever had any problems in the following areas?

Eyes (Ocular symptoms)		
Eye pain or soreness	Yes	No
Fatigue/tired eyes	Yes	No
Dry/gritty feeling	Yes	No
Redness	Yes	No
Burning	Yes	No
Itching	Yes	No
Excess watering	Yes	No
Mucous discharge	Yes	No
Chronic infections	Yes	No
Squinting	Yes	No
Glare/light sensitivity	Yes	No
Halos around lights	Yes	No
Double vision	Yes	No
Loss of vision	Yes	No
Blurred vision	Yes	No
Flashes	Yes	No
Floaters	Yes	No
Constitutional		
Fever	Yes	No
Weight loss or gain	Yes	No
Skin		
Rosacea	Yes	No
Metal allergies	Yes	No
Ear, Nose, Throat, Mouth		
Allergies/hay fever	Yes	No
Sinus infections	Yes	No
Hearing Loss	Yes	No
Respiratory		
Asthma	Yes	No
Chronic bronchitis	Yes	No
Emphysema	Yes	No
Vascular/Cardiovascular		
Heart disease/problems	Yes	No
High blood pressure	Yes	No
High cholesterol	Yes	No
Stroke	Yes	No
Gastrointestinal		
Acid reflux	Yes	No
Intestinal problems	Yes	No
Liver/spleen problems	Yes	No
Endocrine		
Thyroid/other glands	Yes	No
Diabetes	Yes	No
Genitourinary		
Genitals/kidney/bladder	Yes	No
Lymphatic/hematologic		
Anemia	Yes	No
Bleeding	Yes	No
Bones/joints/muscles		
Rheumatoid arthritis	Yes	No
Muscle/joint pain	Yes	No
Neurological		
Headaches	Yes	No
Seizures	Yes	No
Alzheimer's	Yes	No
Parkinson's	Yes	No
Psychiatric	Yes	No
Immune system	Yes	No

PLEASE COMPLETE THE BACK SIDE ALSO

DILATION CONSENT INFORMATION

Dilation of the pupils of your eyes is an important component of every comprehensive eye exam. The purpose of a dilated fundus exam is to make the pupils larger so as to enhance the detection of any ocular pathology such as cataracts, glaucoma, macular degeneration, retinal detachments, malignant growths, retinal hemorrhages, etc. Additionally, illnesses such as high blood pressure and diabetes can be detected during a thorough evaluation of eye structures. Having your pupils dilated is a relatively painless procedure. It should be noted, however, that there are some minor side effects associated with having your pupils dilated. These include mild burning upon instillation of the drops, sensitivity to light, inability to focus at near, and blurry distance vision for some patients. These side effects should last no longer than 4 to 6 hours. Some patients find it difficult to drive after being dilated and thus bring a driver with them. Others find it difficult to do desk/close work immediately after being dilated.

_____ Yes, I wish to be dilated.

_____ No, I do not wish to be dilated.

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received/reviewed a copy of Jane M. Therrien, O.D., Notice of Privacy Practices.
Date _____ Print Name _____

_____ Signature

OFFICE PAYMENT POLICY

CO-PAYMENTS: Due each visit after seeing the doctor.
INSURANCE: We will bill your insurance as a courtesy. Your signature gives us permission to bill your insurance. Deductibles, patient balance responsibility beyond insurance, and all balances are due in full. Bill is not finalized until statement is received from insurance company.
SELF-PAY: Payment is due in full at time of service. There is a $25.00 charge on all returned checks.
PATIENT RESPONSIBILITY: Balances are due in full at the time of service.
NON-COVERED SERVICES: Services not covered by insurance are the responsibility of the patient/guardian. Non-covered services vary between each insurance company.

I have read the above Office Payment Policy and as a patient, or legal guardian of a minor or impaired patient, I understand that regardless of any insurance coverage I may have, I am responsible for payment of my account. I understand there is no fee accrued on current accounts, however, I am also aware that delinquent accounts beyond 90 days are subject to other collection means at my own expense, including, but not limited to a $20.00 per month charge to help defray the cost of a severely delinquent account.

I have read, understand and agree to the above Office Payment Policy in accordance with the terms and conditions set forth in the policy of this office. I also hereby attest that I have given payment information to the best of my knowledge for complete and timely payment.

_____ Signature

_____ Date

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WESTONFAMILYEYECARE@YAHOO.COM

Lifestyle Index

PT INITIALS / ID _____

DATE _____

This questionnaire is meant to help your doctor understand what you're experiencing on a regular basis — whether it's caused by your eyes, posture, stress, etc. Your responses will help make sure you receive the best care possible.

How often do you experience any of these symptoms? Fill in applicable circle. For example: 1 2 3 4 5 ○ ○ ● ○ ○

Headaches
of any severity each week, usually getting worse later in the day

1 Never ○ | 2 Rarely ○ | 3 Sometimes ○ | 4 Very Often ○ | 5 Always ○

Stiffness / pain in neck / shoulders
when you work at a computer or read

1 Never ○ | 2 Rarely ○ | 3 Sometimes ○ | 4 Very Often ○ | 5 Always ○

Discomfort with Computer Use
in your eyes (redness, burning) after long hours looking at the screen

1 Never ○ | 2 Rarely ○ | 3 Sometimes ○ | 4 Very Often ○ | 5 Always ○

Tired Eyes
with increasing feeling of eye fatigue throughout the day

1 Never ○ | 2 Rarely ○ | 3 Sometimes ○ | 4 Very Often ○ | 5 Always ○

Dry Eye Sensation
feeling progressively more gritty/sandy while working at computer or reading

1 Never ○ | 2 Rarely ○ | 3 Sometimes ○ | 4 Very Often ○ | 5 Always ○

Light Sensitivity
especially with brighter, stronger lights like fluorescents or headlights

1 Never ○ | 2 Rarely ○ | 3 Sometimes ○ | 4 Very Often ○ | 5 Always ○

Dizziness
or an experience like motion sickness or vertigo

1 Never ○ | 2 Rarely ○ | 3 Sometimes ○ | 4 Very Often ○ | 5 Always ○

FOR OFFICE USE

neurolens Value	Prism Split for Order Entry	Misalignment	Mono PD	MQI	AC/A Ratio
	OD:	Near:	OD:	Near:	
	OS:	Distance:	OS:	Distance:	

DRS and SD-OCT Exam Imaging

We, at Weston Family Eyecare, are pleased to provide our patients with advanced digital retinal exams using a Digital Retinography System (DRS) as well as Spectral Domain Ocular Coherence Tomography (SD-OCT). The DRS exam generates a high resolution screening photograph of your retina and the SD-OCT generates a retinal image similar to that of an MRI. Both of these images will help Dr. Therrien document, review, and compare specific characteristics of your retina over time and serve not only as a baseline image for our charts, but also screen for eye diseases. These breakthroughs in technology improve our ability to view your internal retinal health at much higher resolutions than the standard slit lamp or ophthalmoscopes.

These exams not only monitor the onset of many ocular diseases, such as macular degeneration, glaucoma, retinal holes, detachments, and diabetic retinopathy (all of which can lead to partial loss of vision or blindness), but can also be used for early diagnosis and treatment of many systemic diseases such as diabetes and hypertension.

When these tests are done, you can expect the following:

- A fast, easy, and painless experience for each imaging process
- An annual high resolution ocular wellness DRS photograph
- An in depth image of the retinal surface (where eye diseases first manifest)
- A complete review of these images with Dr. Therrien
- A permanent record for your medical file for serial analysis, comparisons, and diagnosis
- The comfort of getting these tests without the necessity of dilation (unless otherwise required by the doctor)

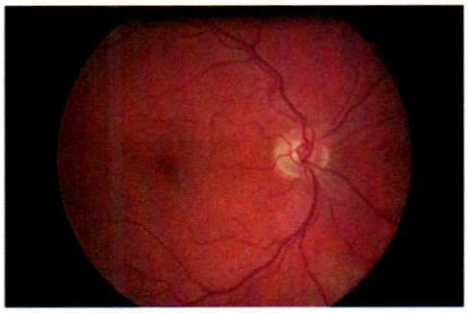
Since insurance will only pay for retinal imaging after discovery of eye disease, the DRS and SD-OCT examinations are considered to be an out of pocket expense.

Dr. Therrien recommends these tests for all patients and will perform them for an additional co-pay of $49.00 that will be added to the basic eye exam you are receiving today. Please select one of the following boxes:

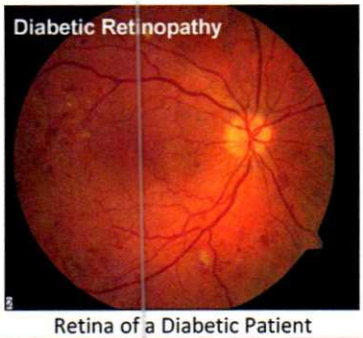
☐ I WOULD like to have my retinal health evaluated with the DRS and SD-OCT exams today.

☐ I DO NOT wish to have the DRS and SD-OCT exams done today. I understand that I will still have a thorough eye examination with slit lamp observation.

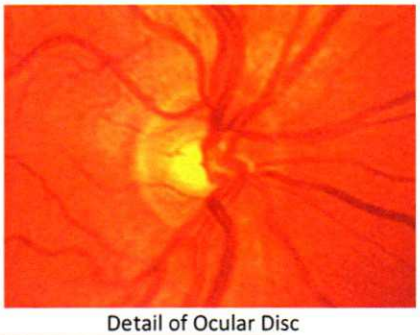
Print Name _____ Date _____ Sign _____



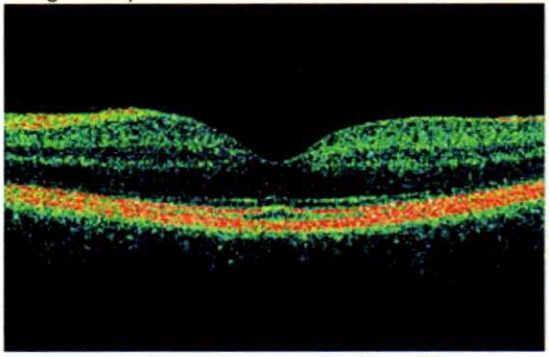
A Young Healthy Retina



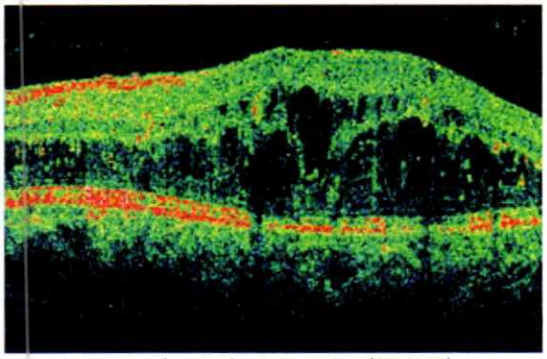
Retina of a Diabetic Patient



Detail of Ocular Disc



Normal retinal cross section (SD-OCT)



Diseased retinal cross section (SD-OCT)