Welcome to the Office of Dr. Marinda D. Hofacre, Doctor of Optometry

(check one) Mr.___ Mrs.___ Ms.___ Miss___ Dr.___
Patient's Name _____ Sex:M/F Age_____ Date of Birth_____
If patient is a minor, parent's name_____
Home Address_____ City_____ State_____ Zip _____
Cell Phone_____ Home Phone_____
E-Mail address_____
Occupation_____Employer_____

Would you prefer to be contacted by Cell ☐ or E-Mail ☐
Primary reason for today's exam: (circle all that apply)
Annual/first eye exam contact lens exam eye health problem LASIK Consultation
Approximate date of last eye exam:_____ Age of present glasses:_____
Do you currently use glasses? YES or NO Do you think you may need glasses? Yes No Not Sure
Do you use contact lenses? YES or NO Are you interested in trying contact lenses today? YES or NO

Are you interested in learning if you are a candidate for Laser Eye Surgery? Yes or NO

Do YOU currently suffer from any of the follow eye/vision problems? *(Circle all that apply)*
Blurred vision Double vision Dry eyes Itchy eyes Blindness/loss of vision
Flashes of light Floaters Crossed or Lazy Eye

In the past, have YOU had any of the following? *(Circle all that apply)*
Crossed Eye Surgery Lasik or Refractive Eye Surgery Cataract Surgery
Retinal Detachment Major Eye Infections Macular Degeneration
Glaucoma Other Eye Disease:_____

Do YOU have any of the following health conditions? *(Circle all that apply)*
Diabetes High Blood Pressure High Cholesterol Heart Disease
Rheumatoid Arthritis Lupus Multiple Sclerosis Thyroid Problems Migraines
Allergies Asthma Cancer (type):_____ Other Diseases:_____

Do YOU suffer from headaches that you think maybe related to your eyes? YES or NO

Are YOU taking any medications? If so, please list:_____
_____
Are YOU allergic to any medications? If so, please list:_____

Do any of your <u>blood relatives</u> have any Eye or Health conditions? *(Circle all that apply)*
Cataracts Glaucoma Macular degeneration Retinal Detachment Keratoconus Blindness
Diabetes High Blood Pressure Heart Disease

Females only: Are You Pregnant or Nursing? YES or NO

**********PLEASE READ AND SIGN OTHER SIDE**********

<u>Current Contact Lens Wearers Please complete below</u>
Type of contacts you wear: *(Circle)* Annual Lens Disposable Astigmatism (Toric) Gas Permeable
What Brand of contacts do you use?_____ Are you happy with them? YES or NO
Do you sleep in your contacts? YES or NO How many hours a day do you wear contacts? _____
How often do you throw you contacts away? _____How old is your current pair of contacts? _____
What solution do you use to care for your contact lenses?_____

NOTICE OF PRIVACY PRACTICES

A Copy of the Notice of Privacy Practices is attached. I have acknowledged and agreed to Marinda D. Hofacre, O.D. and Associates, (DBA The Hofacre Optometric Corporation), Notice of Privacy Practices. A laminated copy is provided on the back of this intake file. A printed copy is available for your records at your request at the front desk.

Initial _____

Authorization to Bill Vision Insurance Plans

I hereby authorize the release of any medical information necessary to my insurance company to provide the most beneficial and complete visual examination. I understand that not all benefits quoted to me are a guarantee of payment by my insurance company and that final determination will be made when my claim is processed. I acknowledge and agree to Marinda D. Hofacre, O.D. and Associates' office policy. **I understand that I am financially responsible for all charges not paid for by my insurance company. I understand that payment is due at time of service.**

Patient Signature _____Date _____

(Parent or legal guardian's signature if patient is a minor.)

Patient's Name_____ Date_____

Optomap and ***iWellness*** Laser Scans

Medical science has shown that mammograms and dental x-rays are vital for the detection and treatment of conditions imperceptible by routine examination techniques. Recent advancements in eye care now aid eye doctors in detecting and preventing many conditions that when missed lead to permanent vision loss or blindness.

Systemic issues such as diabetes, high blood pressure and even cancers (most often breast and lung) can be detected with a retinal image guided eye exam. The **Optomap** image will allow you and the doctor to view the health of the back of your eye together. This way, the doctor can track and compare any minor changes that take place over the year that could lead to vision loss. This state of the art screening is requested by your doctor annually for patients of all ages.

A laser scan**, *iWellness* Scan**, is also recommended for our patients over 18. Diabetic retinopathy, macular degeneration and glaucoma are some of the leading causes of blindness. Many of these conditions can be inherited. Unfortunately as we age, the likelihood of being affected by these diseases increases. *iWellness* screening allows the doctor to exam the microscopic layers of your retina. It helps the doctor diagnose conditions much earlier, as it allows them to evaluate the deep layers of your retina. We care about your vision and health and in order to best take care of you, we recommend a baseline *iWellness* scan and follow up screening annually.

A recent study revealed that 85% of ocular physicians missed a significant clinical finding during a routine eye exam; however, when a Optomap was performed the condition was detected a majority of the time.

This screening process only takes a few minutes and is completely painless. Dilation is not needed for either of these tests and your results will be documented permanently. While this is the preferred method of looking at the eye, screening is elective. We offer this proven technology for the exceptional package price of $39. If you prefer you may elect for only the Optomap scan or *iWellness* scan for $29 each. Dilation is also available for $29.

Just because you see well, doesn't mean your eyes are healthy.

_____Yes, I elect to have both the iWellness and Optomap scans for $39.

_____Yes, I elect to have only the Optomap scan for $29 for patients under 18yo.

_____ Unsure, I would like to speak to the doctor more first.

Patient's Signature_____

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I decline iWellness, Optomap and Dilated Fundus Exam after discussing risk and benefits with my doctor.

Patients' Signature_____

Patient is receiving these services elsewhere. _____ (Doctor's initails)