DRIFTWOOD VISION CENTER
3830 South A1A, Unit 11
Melbourne Beach, FL 32951

Brett C. Reynolds, OD.

Welcome to our office!

The mission of Driftwood Vision Center is to contribute to a lifetime of healthy vision, providing each patient with the highest quality vision care and consequent quality of life. We will seek continuing education to remain at the forefront of our profession and will offer the latest eye care technology, professional services and products. The visual needs and wellness of each patient will always be our first priority. Everything we do shall communicate this. The information and questions below will remain confidential and are critical to the evaluation of your vision and health. With that in mind, it is very important that every question be answered in detail. Thank you.

Patient Information **Today's Date**_____

NAME_____DATE OF BIRTH_____AGE:_____ SEX M F

RACE (Please circle) White Black Asian Hispanic Other

ADDRESS_____SS#_____
(Street) (City, State, Zip Code)

EMAIL_____HOME PHONE_____ CELL/WORK_____

NAME/LOCATION OF PRIMARY CARE PHYSICIAN_____DATE OF LAST EXAM_____

NAME/LOCATION OF LAST EYE EXAM_____DATE OF LAST EXAM_____

EMPLOYER/SCHOOL_____OCCUPATON_____IF STUDENT, GRADE_____

NAME OF SPOUSE/PARENT (Please circle)_____SPORTS/HOBBIES_____

VISION INSURANCE_____MEDICAL INSURANCE_____FLEX SPENDING? YES NO

Dialation Reversal Drops Available At A Cost Of $5.00 ***( ) Yes*** ***( ) No***

ALLERGIES TO MEDICATIONS? ( ) NONE ( ) YES PLEASE L IST_____

CURRENT MEDICATIONS? ( ) NONE ( ) YES_____
Including prescription, over the counter, natural herbs, vitamins and birth control

DO YOU USE: TOBACCO PRODUCTS? ( ) YES ( ) NO DRINK ALCOHOL ( ) YES ( ) NO USE DRUGS ( ) YES ( ) NO

IF YES, TYPE/AMOUNT/HOW LONG_____

CHECK ANY MEDICAL CONDITIONS THAT APPLY TO YOU **( ) NONE**

( ) Diabetes	( ) Vascular Disease/Stroke	( ) Cancer	( ) Skin Eczema/Rash
( ) High Blood Pressure	( ) Seizures	( ) Thyroid Disease	( ) Kidney/Bladder
( ) High Cholesterol	( ) Lung Disease/Asthma	( ) Arthritis	( ) Psychiatric
( ) Heart Disease	( ) Headaches/Migraines	( ) Weight Loss/Gain	( ) Autoimmune

CHECK ANY EYE CONDITIONS THAT APPLY TO YOU **( ) NONE**

( ) Glaucoma	( ) Macular Degeneration	( ) Turned Eyes	( ) Eye Surgery
( ) Cataracts	( ) Dry Eyes/Allergies	( )Eye Injury	( ) Other_____

CHECK CONDITIONS THAT ARE PRESENT IN OTHER FAMILY MEMBERS **( ) NONE**

( ) Glaucoma	( ) Retinal Detachment	( ) Blindness	( ) Cancer
( ) Cataracts	( ) Turned/Crossed Eyes	( ) Diabetes	( ) Heart Disease
( ) Macular Degeneration	( ) Lazy Eye	( ) High Blood Pressure	( ) Thyroid Disease

How did you hear about our office?_____

WHAT ARE THE MAIN REASONS FOR TODAY'S APPOINTMENT (PLEASE CIRCLE ONE OR MORE)

( ) Distance blurred vision	( ) Dry/burning eyes	( ) Eye pain or soreness	( ) One eye turns in or out
( ) Near blurred vision	( ) Eye watering or tearing	( ) Foreign matter in eyes	( ) Seeing flashes of light
( ) Sudden loss of vision	( ) Unusual light sensitivity	( ) Eyelids matted shut	( ) Floating spots in vision
( ) Frequent eyestrain	( ) Eye itching or allergies	( ) Mucous discharge eyes	( ) Other_____
( ) Frequent headaches	( ) Red eyes	( ) Double vision	

LIFESTYLE QUESTIONNAIRE (PLEASE CHECK Yes or No)

Are you planning on purchasing glasses at your visit?	( ) Yes	( ) No	( ) Only if there is a change
Do you have problems with your current glases or contacts?	( ) Yes	( ) No	
Do your eyes tire quickly while reading?	( ) Yes	( ) No	
Do you spend time/work outdoors?	( ) Yes	( ) No	How many Hrs/Wk?_____
Do you have trouble with night driving	( ) Yes	( ) No	
Do you use a computer?	( ) Yes	( ) No	How many Hrs/Day?_____
Are your eyes sensitive to sunlight/bright light?	( ) Yes	( ) No	
Do you have prescription sunglasses?	( ) Yes	( ) No	
Do you think you might benefit from thinner/lighter lenses?	( ) Yes	( ) No	
Do you prefer not to wear your glasses at times?	( ) Yes	( ) No	
Are you interested in Laser Vision Correction?	( ) Yes	( ) No	
Are you interested in nonsurgical vision correction?	( ) Yes	( ) No	
Do you have more than 1 pair of current prescription glasses?	( ) Yes	( ) No	
Do you have children?	( ) Yes	( ) No	
Do you have family members in need of eyecare?	( ) Yes	( ) No	

COMPUTER USER QUESTIONNAIRE: Do you notice any of these visual problems while at the computer?

( ) Headaches during or after working at the computer	( ) Distance vision blurry when looking up from the computer
( ) Burning eyes	( ) Letters on the screen run together
( ) Dry, tired or sore eyes	( ) Need to rest eyes frequently at work
( ) Overall bodily fatigue or tiredness	( ) Driving/night vision worse after computer use
( ) Neck, shoulder or back pain	( ) "Halos" appear around objects on the screen

Many people experience a variety of symptoms after working at their computer for some period of time. If you answered yes to any of the questions above, there is a new type of eyewear lens that can eliminate they symptoms and dramatically improve your comfort level when working on a computer. These eyewear lenses result from a new vision testing technology, developed specifically for computer users. Please make sure to discuss these issues with the doctor.

CONTACT LENS HISTORY AND QUESTIONNAIRE (check all that apply)

( ) I am not interested in contact lenses
( ) I have never worn contacts, however, I am interested in wearing contact lenses and would like to discuss my options
( ) I am not satisfied with the comfort of my current contact lenses
( ) I am not satisfied with the vision of my current contact lenses
( ) I currently wear contact lenses. If so what type:_____Solution_____Sleep in your lenses? YES NO

How often do you replace your contacts? DAILY BI-WEEKLY MONTHLY BI-MONTHLY QUARTERLY YEARLY

CONSENT FORM

I consent to the use and disclosure of my health information for purposes of treatment, payment and healthcare operations. I authorize the same to assignment of benefits from my insurance company.

Please be advised if you are using insurance coverage for today's visit, this is a contract between you and your insurance company, not Driftwood Vision Center. If your insurance company has not reimbursed our office in full within 90 days, you may be billed and your insurance company will then pay you directly.

C: newpatient.doc

Signature_____

HEALTH INFORMATION RELEASE FORM

In order to assist you in receiving your health information from Driftwood Vision Center, please complete this form.

I authorize the persons listed below to have access to any and all of my health information, including eyeglass prescription, contact lens prescription, diagnosis and treatment of Ocular Diseases. Driftwood Vision Center is permitted to share any medical information disclosed during office visits.

Persons or organization authorized to receive my medical information (full name and phone numbers): example spouse or other doctor's office

_____

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You may notify me or the parties listed above with normal test results, appointment reminders and other information regarding my health information as follows:

( ) Message on answering machine (phone number_____)
( ) Message on work voice mail (phone number_____)
( ) Message on cell phone (phone number_____)
( ) Other_____

My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment), however, I do have to sign an authorization form to take part in a research study or to receive health care when the purpose is to create health care information for a third party.

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Brett C. Reynolds, O.D., P.A. and staff based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. To revoke this authorization:

Write to:
Donald C. Reynolds, Privacy Officer
3830 S. Highway A1A, Unit 11
Melbourne Beach, FL 32951

Once health care information is disclosed, the person or organization that received it may re-disclose it. Privacy laws may no longer protect it. Driftwood Vision Center complies with all HIPPA any other federal privacy regulations. I acknowledge that I have been made aware of my rights to review or obtain a copy of the policies.

_____ _____
Patient Signature Witnessed by

_____ _____
Patient Date of Birth Date Signed

C: newpatient.doc