

Please answer the following questions to help us better determine what your visual needs are.

Nature of your visit: (Why are you here?) Please check ALL THAT APPLY.

- I want my annual eye exam.
- I broke/lost my glasses.
- I want new glasses.
- I want contact lenses.
- I want _____

I currently wear: (Please put what you have worn during the last year, even if you lost them.)

- Glasses
- Contacts
- I don't wear glasses or contact lenses

Contact Lens Fit & Follow-up policy:

- Contact Lens Fitting costs
 - Basic Fitting: \$50.00
 - Specialty Fitting: \$70.00
 - All scheduled follow up exam must be completed **within 30 Days**.
 - Failure to complete your follow up exam **within 30 DAYS** will result will require a complete reexamination. Including all applicable fees.
 - There is no additional charge for scheduled contact lens follow-up appointment as long as you keep it within the 30 days.
 - If you want colored contacts, you must notify Dr. Ford during today's visit. Failure to do so will require a complete refit and all applicable fees.
- Please SIGN HERE in agreement that you read and understand this policy: _____

ALLERGY SYMPTOM CHECKLIST:

If you experience any of the following symptoms you may be suffering from Ocular Allergies, an easily treatable problem. Please circle the number that best describes how you feel.

0 = no problem 1 = occasional problem 2 = mild problem 3 = moderate problem 4 = severe problem 5 = I am about to die

- | | | | | | | |
|--|---|---|---|---|---|---|
| My eyes are red..... | 0 | 1 | 2 | 3 | 4 | 5 |
| My eyes itch..... | 0 | 1 | 2 | 3 | 4 | 5 |
| My eyes water..... | 0 | 1 | 2 | 3 | 4 | 5 |
| My eyes are crusty in the morning..... | 0 | 1 | 2 | 3 | 4 | 5 |
| My eyes swell overnight..... | 0 | 1 | 2 | 3 | 4 | 5 |

DRY EYE SYMPTOM CHECKLIST:

If you experience any of the following symptoms you may be suffering from Dry Eye Syndrome, an easily treatable problem. Please circle the number that best describes how you feel.

0 = no problem 1 = occasional problem 2 = mild problem 3 = moderate problem 4 = severe problem 5 = I am about to die

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|---|---|---|---|---|---|---|
| My eyes feel gritty or sandy..... | 0 | 1 | 2 | 3 | 4 | 5 |
| My eyes burn..... | 0 | 1 | 2 | 3 | 4 | 5 |
| My eyes tear..... | 0 | 1 | 2 | 3 | 4 | 5 |
| My eyes are uncomfortable in windy conditions..... | 0 | 1 | 2 | 3 | 4 | 5 |
| My eyes are uncomfortable when the car A/C blows on them..... | 0 | 1 | 2 | 3 | 4 | 5 |

RETINAL HEALTH SCREENING

Golden Triangle Eye Clinic is pleased to provide our patients with advanced digital retinal documentation services. This service is a digital screening image of your retina which will help us document, review, and compare your overall eye health over time. We use the digital screening image of your retina to look for eye diseases and improve our ability to maintain your eye health.

We are concerned about retinal problems such as macular degeneration, glaucoma, and diabetic retinopathy (all of which can lead to partial loss of vision or blindness). Additionally, many systematic diseases such as diabetes and the effects of high blood pressure can be followed over time.

What you can expect from this screening:

- A permanent visual record of your eye and any changes that may occur.
- The ability to review the images with you. (A picture is worth a thousand words!)

Dr. Ford recommends this procedure for all of his patients and will perform the retinal screening exam at an additional cost of only \$20.00. This is NOT covered by your insurance.

I AGREE TO have my retinal health evaluated with the retinal screening photograph exam.

I DO NOT wish to have the retina screening photograph exam. I understand that I will still have a thorough eye examination with slit lamp observation.

DILATION CONSENT

It is our goal to provide a complete and thorough comprehensive eye examination. To effectively accomplish our goal, we feel it is important to dilate the pupils of your eyes. This will require placing drops in your eyes which will open the pupil and allow a better view of the inside of your eye.

As with many medications, there are some side effects of the drops used to dilate the pupil. These include sensitivity to light and blurred vision (in most cases the distance vision will be unaffected). The side effects usually last several hours but rarely last as long as 24 hours.

While we believe dilation is an important part of the eye examination process, we understand that some patients may wish to omit this procedure. This service can be performed at an additional cost of only \$20.00

I AGREE to be dilated today.

I DO NOT WISH to be dilated and agree to hold Dr. Ford, and Golden Triangle Eye Clinic harmless as a result of my actions.

Patient Signature Required: _____ Date _____

Under 18 Guardian Signature Required: _____ Date _____