SPECTRUM EYECARE Optometry™

425 W. Bonita Ave., Suite 110B | San Dimas, CA 91773
(909) 394-0462 | Fax: (909) 394-0014
www.SpectrumEyecareOptometry.com

Welcome to Our Office!

Date: _____

Patient Information

Patient Name: _____ Date of Birth: ____/____/____
Mailing Address: _____ Gender: ☐ M ☐ F
Home Phone: _____ Work Phone: _____ Cell Phone: _____
City: _____ State: _____ Zip: _____
Email Address: _____
Occupation: _____ Employer/School: _____
Whom may we thank for referring you? _____

Medical History

Have you or any of your relatives been diagnosed with any of the following? Please list family member and relationship (ie: paternal/maternal grandparent)

	You	Family Member	
Cancer	☐	☐	_____
Cataracts	☐	☐	_____
Diabetes	☐	☐	_____
Dry Eye	☐	☐	_____
Glaucoma	☐	☐	_____
Hay Fever (Allergies)	☐	☐	_____
Heart Disease	☐	☐	_____
High Blood Pressure	☐	☐	_____
Kidney Disease	☐	☐	_____
Macular Degeneration	☐	☐	_____
Migraines	☐	☐	_____
Neurological Disorders	☐	☐	_____
Stroke	☐	☐	_____
Thyroid Disease	☐	☐	_____
Turned or Crossed Eye	☐	☐	_____

Primary Care Physician: _____
Primary Care Phone Number: _____
Date of Last Physical Exam: _____
Height: _____ Weight: _____ BMI: _____
Medications (Including OTC and Vitamins): _____
_____
Are you allergic to any medications? _____
Do you smoke? ☐ Yes ☐ No How often? _____
Are you currently pregnant? ☐ Yes ☐ No
Breastfeeding? ☐ Yes ☐ No
Date of Last Eye Exam: _____
Do you wear contact lenses? ☐ Yes ☐ No
Brand: _____
If you do wear contact lenses, are you having any problems?
☐ Yes ☐ No (If yes, please explain) _____
_____
Please describe any eye injuries/surgeries/diagnoses you have had: _____
Are you currently having any eye related issues? ☐ Yes ☐ No
(If yes, please explain) _____
_____

Vision Benefits Company: _____
ID# _____
Primary Member Name: _____

Medical Insurance Company: _____
ID#: _____
Primary Member Name: _____

I authorize my insurance/benefits company to pay for all services or products obtained.
I understand that I am responsible for any charges denied by my insurance/benefits company.

Signature: _____
Parent/Guardian Name Printed (if patient is under 18): _____

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Services and Products Offered by Spectrum Eyecare Optometry

A $39 out of pocket expense will be billed today at the time of service for our comprehensive pre-testing, which includes:

iWellness OCT by Optovue Scan
Similar to an x-ray that your dentist might use, but totally harmless since it uses soundwaves and takes only seconds to perform, the iWellnessExam™ provides high definition cross sections of your retina which allows your doctor to see with unprecedented clarity what is invisible with traditional examination methods.

Early Detection is Crucial! Sight threatening diseases such as glaucoma, macular degeneration and others often have no outward signs or symptoms in early stages, which is why eye exams, including a thorough retinal evaluation, are so important to protect vision. As the most important development in eye care in the last decade, the OCT scan uses breakthrough technology that can help detect potential vision threatening diseases in their early stages when they are most treatable.

Retinal Imaging
Digital retinal imaging is a technology which involves capturing a high-resolution digital image of the interior portion of your eye, the retina. This technology provides us with a digital retinal fingerprint and serves as a baseline for comparison at future visits. It is an excellent tool for preventative care. We emphasize imaging if: ***You have a family history of eye disease, including glaucoma, blindness, retinal detachment, macular degeneration, or other eye conditions. You are diabetic, hypertensive, have rheumatoid arthritis, or use high-risk medications, including steroids, Chloroquine or Amiodarone.*** Digital imaging is quick, and the photographs are available immediately.

☐ YES, I would like the comprehensive pre-testing, as recommended by the doctor.
☐ NO, I choose to pass on these important tests.

Dilation
Spectrum Eyecare Optometry recommends each patient have a dilated comprehensive eye examination every year or as medically indicated. Dilation consists of eye drops administered in conjunction with your eye exam. The drops enlarge the pupil, allowing the doctor a more thorough examination of the eye, specifically of the retina. The procedure can detect ocular diseases, such as macular degeneration, glaucoma and optic nerve disease, as well as systemic diseases, such as hypertension and diabetes. Please initial below.

☐ YES, I would like to have my eyes dilated today to facilitate a thorough and complete eye exam.
☐ NO, I do not want to have my eyes dilated today.

Privacy Policy

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for services, and to conduct healthcare operations involving our office. The Privacy Policy describes these uses and disclosures in detail.

I acknowledge that I received a copy of Spectrum Eyecare Optometry Inc.'s Notice of Privacy Practices.

Patient Name: _____

Signature: _____ Date: _____