Welcome to Spring Creek Eye Care, PLLC

Please take a moment to fill out this form to help us meet your eye care needs. Insurance inquires must be made prior to the examination

Patient Information

Name (Last, First):__________________________ Today's Date:____________________
Address:____________________________________ Home Phone:____________________
City:__________________ State:_______ Zip:__________ Work/Cell Phone:________________
Guardian(if applicable):________________________ Occupation:____________________
Date of Birth (MM/DD/YY):______________________ Age:__________________________
Email:______________________________________ Last Eye Exam Date:______________
Employer or School(if patient is a student):____________ Grade:_________________________

Insurance Information/Guardian

Medical Insurance Name(write below) Patient ID #/Group #
______________________________ ______________________________
Primary cardholder's Name(if different from above) Primary cardholder's DOB
______________________________ ______________________________
Primary cardholder's Social Security Number Primary cardholder's relationship to patient
______________________________ ______________________________
Primary cardholder's Address(if different from above) Primary cardholder's employer
______________________________ ______________________________
Vision Insurance Company Patient ID Number
______________________________ ______________________________

NEW PATIENTS ONLY:

Who may we thank for referring you to our office? Name of friend or relative:_______________________
How did you hear about us? Lenscrafters Optical_____ Website/Internet Listing_______ Sign outside__________
Insurance provider list/book__________ Other_____________________________

Patient Eye History and Eyewear needs

Do you wear glasses? Yes ❑ No ❑ How old is your present pair of glasses?____________________
Do you wear contact lenses? Yes ❑ No ❑ if so, what brand?________ Replacement schedule:__________
Are you satisfied with the vision and comfort of your contact lenses? Yes ❑ No ❑
Check any of the following you may have had: ❑ Crossed Eyes ❑ Lazy Eye ❑ Dropping eyelid ❑Glaucoma ❑ Retinal Disease ❑ Eye Infections ❑ Eye Injury ❑ Eye Surgery Date Occurred:____________________

Medical History

Do you have any allergies to medications? Yes ❑ No ❑ if yes, explain____________________
List any medications you take (including oral contraceptives, aspirin, over-the-counter, & home remedies):
____
____
____
List all major injuries, surgeries and/or hospitalizations you may have had:
____
Are you currently pregnant? Yes ❑ No ❑ Nursing? Yes ❑ No ❑

Social History: This information will be kept confidential. However you may discuss this portion directly with the doctor if you prefer.

Do you drink alcohol? Yes❑ No❑ Do you smoke? Yes❑ No❑
Do you have a history of drug abuse? Yes ❑ No❑ Do you drive? Yes ❑ No❑

-OVER-

Patient's Medical History/Review of Systems-*Circle Yes or No*	**Eyes (Ocular Symptoms)-***Circle Yes or No*
Y N General: (Weight loss, Fever, Headache)	Y N Burning or Dryness
Y N Ear/Nose/Throat: Hearing loss, Sinus problems	Y N Blurry or Distorted Vision
Y N Heart: Chest Pain, Irregular Heart Beat	Y N Double Vision
Y N Respiratory: Short of breath, Wheezing, Asthma, Cough	Y N Excessive Tearing/Watering
Y N Digestive: Heartburn, Diarrhea, Reflux	Y N Eye pain or Soreness
Y N Neurologic: Paralysis, Numbness	Y N Flashes/Floaters in Vision
Y N Skin: Rashes, Eczema	Y N Fluctuating Visual Acuity
Y N Psychiatric: Depression, Anxiety, Mental Illness	Y N Itching
Y N Endocrine: Diabetes, Thyroid	Y N Loss of Vision
Y N Cancer: Any type	Y N Loss of Peripheral Vision
Y N Blood: Anemia, Sickle Cell, Excessive Bleeding	Y N Mucous Discharge
Y N Urinary: Kidney, Bladder Issues	Y N Redness
Other: Please List________________________	Y N Sandy or Gritty Feeling

Self/Family History: *Indicate family history (parents, grandparents, siblings, children, etc) for the following conditions*

Disease/Condition	**Self**	**Family**	**Relationship (*and state maternal or paternal)***
Blindness	❑	❑	________________________
Cataracts	❑	❑	________________________
Glaucoma	❑	❑	________________________
Macular Degeneration	❑	❑	________________________
Retinal Problems	❑	❑	________________________
Eye Surgery	❑	❑	________________________
Lazy Eye	❑	❑	________________________
Diabetes	❑	❑	________________________
High Blood Pressure	❑	❑	________________________
High Cholesterol	❑	❑	________________________
Heart Disease	❑	❑	________________________
Thyroid	❑	❑	________________________
Cancer	❑	❑	________________________
Arthritis	❑	❑	________________________
Lupus	❑	❑	________________________
Other	❑	❑	________________________

DILATION *PLEASE READ CAREFULLY*

Dilation is the relaxing and opening of the pupils by using medicated eye drops. This allows a better view of the retina and helps the doctor to detect many eye conditions that may be missed during a routine eye exam. Dilation is strongly recommended for patients with a history of cataracts, high blood pressure, or older than 40 years of age. However, dilation is mandatory for patients with a history of diabetes, glaucoma and sometimes young children. After dilation, you may experience increased light sensitivity, inability to focus up close, a slight blurring of your distance vision but most patients can see well enough to drive. These side effects usually last 3-4 hours. We will provide you with a disposable pair of sunglasses for your comfort.

❑ **Yes, I do consent to having my eyes dilated**. ❑ **Yes, but I would like to reschedule for another day**.

❑ **No, I do not want dilation.** By signing below, I understand and release Dr. Lorena de la Garza and their doctors from all liability to treat or diagnose any eye condition due to lack of diagnostic information, which could have been obtained from the dilation.

Please sign here if you DO NOT want dilation. **X**________________________ **Date:**__________

VISUAL FIELDS TESTING

A computerized device will be used to test your peripheral vision. This test helps to detect many types of visual fields loss caused by eye diseases such as glaucoma, brain tumor, retinal tear, or optic nerve defects that cannot be detects with a comprehensive dilated exam. With early detection, this can prevent may blindness-causing disease before it is too late. This test does not require eye drops. ***The cost of this test is an additional $30.***

❑ ***Yes, I would like to have this test done today.*** ❑ ***No, I decline***.

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