Patient Name:_____ Date:_____

Are you currently being treated for any of the following?

___High blood pressure ___ Diabetes ___ Heart Disease ___Stroke
___Pregnancy (Breast Feeding) ___Glaucoma ____ High cholesterol

Please list any medications that you take, prescription or non-prescription:
_____
_____
_____
_____
Please list any allergies and the reaction:
_____
_____

Pharmacy name and address: _____
Are there any new health problems since your last visit? If yes please list them:
_____
Do you smoke? Y N If so how much?_____
Are you currently having any vision problems with your old prescription? Yes No
If yes please describe the problem: _____
_____

Have you had any problems with your eyes since your last visit? Yes No
If yes please describe the problems: _____
_____
Do you want to order contacts within the next year? Yes No

If applicable, are you having any problems with your current contacts: Yes No

If yes please describe problems:_____
_____
May we contact you via text or email to
____ Send you appointment reminders.
____ Send you notices of new services or products.
____ Send you notices of sales and specials

Cell Phone number:_____
_____
Patient Signature

OptoMap®
Retinal Exam

In our continued efforts to bring the most advanced technology available to our patients, Dr. Miller now offers the inclusion of the **Opto**map Retinal Screening as an integral part of your eye exam. We recommend it for all patients once a year.

An **Opto**map Retinal Screening provides:

- A scan to confirm a healthy eye or detect the presence of disease early.
- An overview of map of the retina, giving you doctor a more detailed and wider view than can be achieved by the traditional "slit-lamp" exam.
- The opportunity for you to view and discuss the **Opto**map images of your eye with your doctor at the time of the exam.
- A permanent record for your medical file, enabling your doctor to make important comparisons if potential problems show themselves at a future exam.

Our fee for the **Opto**map Retinal Screening is $41.*

_____ I have elected to have the **Opto**map Retinal Screening today and understand that I will be charged a fee of $41.00.

_____ I would like the opportunity to talk with the doctor or technician about the **Opto**map Retinal Screening

Patient Signature:_____ Date:_____

*A **<u>High Resolution</u>** **Opto**map Retinal Exam is recommended for any patient with a history of diabetes, glaucoma, hypertension, or any patient that has a screening and a problem presents. The High Resolution Optomap Retinal Exam will be billed to your medical insurance along with any additional tests that may be required. **As a courtesy, we will waive the fee for the screening and the patient will only be responsible for their standard specialist copay.** This copay **does not** include any copay for the annual routine vision exam.