

Dr. Brian Joslin
Dr. Bryce Joslin
Optometrists

Drs.
**Joslin
& Joslin**
EYE CENTER

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WELCOME TO THE 21ST CENTURY

Dear Patient,

A new, highly sophisticated computerized instrument now allows us to provide you with a more thorough medical analysis of your eye. The digital retinal imaging system takes images of the retina (the back of your eye), and other structures inside the eye. This procedure assists the doctor in the early detection of many disorders, including glaucoma, diabetic retinopathy, macular degeneration, retinal detachments and other vision threatening conditions. **The images will be stored in the computer and compared with images from future exams. This allows the doctor to observe even the smallest amount of change from the previous procedure.** This procedure does not take the place of dilation.

The doctor strongly recommends that **all patients** have this procedure performed. It is especially important for people who have:

- 1) Headaches
- 2) See spots or flashes
- 3) Family history of diabetes
- 4) Family history of glaucoma
- 5) Family history of high blood pressure
- 6) High cholesterol
- 7) Reached the age of 40
- 8) Experienced sudden vision changes
- 9) New Patients
- 10) Patients who have never had the procedure

There is an additional charge of \$35.00 for this procedure. If a diagnosis is made during your examination, additional imaging may be done and insurance will cover this part of the procedure. Please check the appropriate line below and sign at the bottom.

_____ **I DO** want the procedure performed. Date _____

_____ **I DO NOT** want the procedure performed. Date _____

PATIENT REGISTRATION

Patient _____ Date _____

Address _____

City _____ State _____ Zip _____

Home Phone _____

Work Phone _____

Cell Phone _____

Sex M F

Birthdate _____ Age _____

Social Security Number _____

Employer _____

Referred By _____

IN CASE OF EMERGENCY

Name _____ Relationship _____

Home Phone _____

Work Phone _____

FINANCIAL RESPONSIBILITY

Who is responsible for this account? _____ Birthdate _____

Relation to patient _____

Social Security Number _____

The responsible party is responsible for payment in full of all services or charges rendered by Joslin Eye Center, P.C. regardless of insurance coverage. Please remember that most insurance companies do not cover all charges in full. Since insurance is a contract between you and your employer or you and the insurance company, you are responsible for any balance for services rendered regardless of any insurance coverage you may have. In the event this account becomes delinquent, the undersigned agrees to pay any necessary collection fees/attorney fees of **no less than 40% added to the unpaid balance**, and court costs.

Responsible Party Signature _____ Date _____

ASSIGNMENT AND RELEASE

I assign all insurance benefits for services rendered, payable directly to Joslin Eye Center, P.C. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorized the use of this signature on all insurance submissions.

Responsible Party Signature _____ Date _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have read a copy of the NOTICE OF PRIVACY PRACTICES of Joslin Eye Center, P.C. I understand that signing this acknowledgement is not a requirement to receive treatment by Joslin Eye Center, P.C.

Responsible Party Signature _____ Date _____

**MEDICAL HISTORY QUESTIONNAIRE
PAST PERSONAL HISTORY**

MEDICATIONS

• _____
• _____
• _____

DRUG ALLERGIES _____

Primary Care Physician _____
Previous Eye Doctor _____
Last Eye Exam _____

Describe all serious illnesses, injuries and surgeries you have had in the past: _____

FAMILY HISTORY

Please note any family member with the following diseases/conditions

M-Mother	F-Father		S-Sibling		GP-Grandparent	
	YES	NO	YES	NO	YES	NO
Arthritis _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes _____	<input type="checkbox"/>
Blindness _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma _____	<input type="checkbox"/>
Cancer _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease _____	<input type="checkbox"/>
Cataracts _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension _____	<input type="checkbox"/>
Crossed Eyes _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Retinal Disease _____	<input type="checkbox"/>

SOCIAL HISTORY

Check which substances you use and consumption

Alcohol YES NO Quantity: _____
 Drugs YES NO Quantity: _____
 Tobacco YES NO Quantity: _____

REVIEW OF SYSTEMS

Check the symptoms and/or conditions you currently have

EYES	YES	NO	?		YES	NO	?
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	GASTROINTESTINAL (Stomach)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	INTEGUMENTARY (Skin)			
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Distorted Vision (Halos)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	LYMPHATIC/HEMATOLOGIC			
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excess Tearing/Watering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye Pain or Soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Flashes/Floaters in vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HIV Positive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glare/Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	NEUROLOGIC			
Infection of Eye or Lid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lazy Eye	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	PSYCHIATRIC			
Retinal Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sandy or Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Styes or Chalazion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	REPRODUCTIVE			
BONE/JOINT/MUSCLE				Pregnant/Nursing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	RESPIRATORY			
Joint/Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Polio	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CANCER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ENDOCRINE				Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Abnormalities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
EAR, NOSE, AND THROAT				VASCULAR			
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

List any other health conditions not mentioned above: _____

Doctors Signature _____ Date _____