



Jonathan Cargo, O.D.

Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your eye health and vision.

Account: _____

Patient Information

Name _____ Date _____
Last Name First Name Initial

Address _____ Apt# _____ Soc. Sec. # _____

City _____ State _____ Zip _____ Home Phone _____

Sex M F Age _____ Birth Date _____ Single Married Widowed Divorced

Occupation _____

Account Responsible

Person Responsible for Account _____
Last Name First Name Initial

Relation to Patient _____ Birth Date _____ Soc. Sec. # _____

Address(if different from patient) _____

City _____ State _____ Zip _____ Home Phone _____

Mobile Phone _____ Business Phone _____

Email _____

How did you learn about our practice?

- Established Patient Insurance Website Direct mail Radio Print Advertisement
- Referred by a Friend (please provide us with their name) _____
- Referred by a Physician (please provide us with their name) _____

Health Insurance Information

Many eye problems are covered by your health insurance

Health Plan _____ Phone _____

Subscriber # _____ Group # _____ Effective Date _____

Subscribers Name _____ Relation to Patient _____ Birth Date _____

Subscriber Employed by _____ Business Phone _____

Do you have a deductible to meet? _____ Deductible amount _____

Vision Plan Information

Vision Plan _____ Phone _____

Subscriber # _____ Group # _____ Effective Date _____

Subscribers Name _____ Relation to Patient _____ Birth Date _____

Subscriber Employed by _____ Business Phone _____

REVIEW OF SYMPTOMS AND FAMILY HISTORY

Please check off any applicable symptoms or problems; your optometrist will obtain additional details if necessary.
If you have no problems in a specific area please indicate by checking off the "none" box.

Primary care Physician: _____ Date of last medical exam _____

Have you had an influenza vaccination with in the last 12 months? Yes No

Are you Pregnant? Yes No If yes, how many months? _____

List any known drug allergies: None _____

List any medications you are taking None _____

List any eye injuries, diseases or surgeries _____

<input type="checkbox"/> GENERAL Fever, night sweats, weight loss, fatigue	<input type="checkbox"/> None	Briefly explain any checked box
<input type="checkbox"/> EYE, EAR, NOSE, THROAT Sinus, otitis, hearing loss, ringing in ears, vertigo, allergies Glaucoma, Cataracts, Retinal disease, other	<input type="checkbox"/> None	
<input type="checkbox"/> CARDIOVASCULAR Heart attacks, cholesterol problems, Congestive heart failure High blood pressure, heart murmurs, chest pains, arrhythmias	<input type="checkbox"/> None	
<input type="checkbox"/> RESPIRATORY Shortness of breath, asthma, wheezing, cough, emphysema, Chronic obstructive pulmonary disease	<input type="checkbox"/> None	
<input type="checkbox"/> GASTROINTESTINAL Colitis, ulcers, acid reflux, Crohn's disease, diarrhea	<input type="checkbox"/> None	
<input type="checkbox"/> KIDNEY, BLADDER, GENITALS Renal failure, dialysis, frequent urination	<input type="checkbox"/> None	
<input type="checkbox"/> MUSCLES, JOINTS, BONES Arthritis, joint pains, fractures, disc problems, other	<input type="checkbox"/> None	
<input type="checkbox"/> SKIN Skin Cancers, rashes, itchiness, other	<input type="checkbox"/> None	
<input type="checkbox"/> NEUROLOGICAL Stroke, Numbness, weakness, balance, Gait, coordination, speech, headaches, migraines, Loss of consciousness, blind spots in vision.	<input type="checkbox"/> None	
<input type="checkbox"/> PSYCHIATRIC Anxiety, depression, insomnia, bipolar, other	<input type="checkbox"/> None	
<input type="checkbox"/> HORMONAL/ ENDOCRINE Diabetes, thyroid problems, pituitary problems, other	<input type="checkbox"/> None	
<input type="checkbox"/> BLOOD/ LYMPHATIC Bleeding problems, anemia, transfusions, blood loss, other	<input type="checkbox"/> None	
<input type="checkbox"/> INFECTIOUS DISEASES HIV, Hepatitis, tuberculosis, other	<input type="checkbox"/> None	

FAMILY HISTORY	Relationship	SOCIAL HISTORY
Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No
Retinal Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Packs per day? _____
Blindness <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	How many years have you smoked? _____
Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No
Heart disease <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	How frequently do you drink? _____
Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	
Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	

Reviewed and discussed with patient

_____ O.D.

Patient Visual Information

What is the primary reason for your visit today? _____

Date of last vision exam _____ Doctor's name _____

Do you wear glasses now? Yes No If yes, for what activities? _____

Do you wear contact lenses? Yes No If yes, how frequently do you replace them? _____

Are you planning on purchasing new glasses today? Yes No only if my Rx changes

Are you interested in trying contact lenses? Yes No

Are you interested in corrective eye surgery? Yes No

Check (✓) if your eyes are bothering you in the following ways:

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Blurry vision at near | <input type="checkbox"/> Blurry vision at distance | | |
| <input type="checkbox"/> Burning/Itching | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Eye pain | <input type="checkbox"/> Loss of sight |
| <input type="checkbox"/> Change in vision | <input type="checkbox"/> Double vision | <input type="checkbox"/> Flaking lids | <input type="checkbox"/> Perceptual difficulties |
| <input type="checkbox"/> Contact lens problem | <input type="checkbox"/> Dry eyes | <input type="checkbox"/> Halos/spots | <input type="checkbox"/> Styes on lids |
| <input type="checkbox"/> Discharge | <input type="checkbox"/> Excessive tearing | <input type="checkbox"/> Light sensitivities | |

List any work activities or hobbies you participate in that may require special visual needs. _____

Recommended Additional Tests

Visual Field Screening

Visual Field Screening uses computerized light flashes to measure for defects in the field of vision.

Possible defects that might be detected include glaucoma, retinal disorders, neurological disease and brain tumors. This testing can provide information in diagnosing headaches. We strongly recommend this test for all adult patients.

The fee for the Visual Field Screening is **\$20.00.**

- To have the screening Not to have the screening

GDx VCC Glaucoma Screening

This new technology is the most advanced and accurate method to detect glaucoma. Millions of Americans suffer from glaucoma and aren't even aware of it. Glaucoma is called the "silent thief of sight" because it has no symptoms and no pain, yet can rob you of your vision. The GDx VCC is a fast, comfortable exam. It takes only one minute and there's no pupil dilation, discomfort or annoying lights. A safe, invisible light measures the back of your eye. The results assist your doctor in determining if you have glaucoma. We highly recommend this exam for anyone new to our practice, with a family history of glaucoma, or those patients over 40 years of age.

The fee for the GDx VCC Glaucoma Screening is **\$35.00.**

- To have the screening Not to have the screening

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the doctor to help determine appropriate treatment. If there is any change in my medical status, I will inform the doctor.

I authorize my insurance company to pay to Cargo Eye Care all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize Dr. Cargo to release all information necessary to secure the payment of benefits. I recognize that Cargo Eye Care is offering me an additional service by filing my insurance claim and waiting for payment. I understand and agree that I am financially responsible for all charges whether or not paid by my insurance.

I acknowledge that I have reviewed, am aware of, and may request a copy of Cargo Eye Care's Notice of Privacy Practices.

Signature _____ Date _____

Payment is due in full at time of treatment unless prior arrangements have been approved.