Mobley Eye Care

B. Dean Mobley, O.D.

Date: _____

Mr. Miss Mrs.
Male Female

_____ _____ _____
First Name MI Last Name

_____ _____ _____ _____
Street Address City State Zip Code

_____ _____ _____ _____
Social Security Date of Birth Age Email Address

_____ _____ _____
Home Phone Work Phone Cell Phone

How will you settle your account today?

CASH CHECK CREDIT CARD CARE CREDIT

Vision Insurance: _____

Subscriber Name: _____

Subscriber SSN: _____

Subscriber DOB: _____

Major Medical Insurance: _____

Subscriber Name: _____

Subscriber SSN: _____

Subscriber DOB: _____

Date of last exam? _____

Have you ever tried contact lenses? Yes or NO

Do you currently wear contact lenses? Yes or NO
What brand? _____
Solutions used? _____

Do you prefer clear or colored? _____

Are you satisfied with the vision and comfort of your contact lenses? YES or NO

If you wear bifocals, do the lines or head tilting bother you? YES or NO

Any problems with your current contact lenses or eyeglasses? YES or NO

(if yes, please explain) _____

What is the major purpose of this visit? _____

Mobley Eye Care is dedicated to promoting education and knowledge to you about your eye health and unique vision needs. We are committed to providing high quality, personalized eye care in a friendly and professional manner. Our services and products will be delivered with integrity, honesty, and compassion.

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By signing below I certify that I have received and reviewed the Notice of Privacy Practices as required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1966 (HIPAA) and that all of my questions have been answered to my satisfaction.

PRINT NAME: _____

Parent or Guardian (if under 18): _____

SIGNATURE: _____

DATE: _____

Date Of last physical checkup? _____
Date of last eye exam? _____
Name of Family Physician? _____
Current medications? _____
_____
Allergies to any medications? YES / NO
If YES, what medications? _____
Have you had any surgeries? _____
If YES, list: _____
Do you use cigarettes, tobacco, alcohol, or substances? YES / NO
If YES, list: _____

Do you…. (check if the answer is YES)

- Work on the computer? How many hours? _____ hrs. per day.
- Think you might benefit from thinner, lighter lenses?
- Spend time outdoors? How much? _____ hrs / wk
- Have prescription sun wear?
- Prefers not to wear your glasses at times?
- Have Children?
- Have family members in need of eyewear?

If there a family medical history of any of the following (if yes, check and tell who.)

- ☐ Blindness _____
- ☐ Cataracts _____
- ☐ Corneal Problem _____
- ☐ Diabetes _____
- ☐ Glaucoma _____
- ☐ High Blood Pressure _____
- ☐ Heart Disease _____
- ☐ Lazy Eye _____
- ☐ Macular Degeneration _____
- ☐ Retinal Problems _____

Have you ever experienced, been diagnosed or treated for any of the following? (if yes, check)

☐ Macular Degeneration	☐ Glaucoma	☐ Cataracts	☐ Retinal Detachment
☐ Floaters / Spots	☐ Blurry Vision	☐ Double Vision	☐ Itchiness
☐ Flashes of Light	☐ Tearing	☐ Burning	☐ Corneal Abrasions
☐ Sunlight Sensitivity	☐ Iritis / Uveitis	☐ Eye Injury	☐ Trouble seeing at night
☐ Occasional Dryness	☐ Eye Infections	☐ Lazy Eye	☐ Headaches
☐ Crossed eye / Eye Turn	☐ Grittiness	☐ Other eye disorder _____	

Have you ever been diagnosed or treated for the following health problems? (if yes, check)

☐ Allergies	☐ Arthritis	☐ Blood / Lymph	☐ Cancer
☐ Cholesterol	☐ Diabetes	☐ Endocrine	☐ Ears / Nose / Throat
☐ Eczema / Rash	☐ Fevers	☐ Genitourinary	☐ High Blood Pressure
☐ Integumentary (skin)	☐ Kidney	☐ Muscle / Bone	☐ Psychological
☐ Respiratory	☐ Sinus	☐ Thyroid	☐ Throat Infections
☐ Fatigue	☐ Digestive	☐ Bronchitis	☐ Neurological
☐ Unusual weight loss / gain	☐ Cancer if yes, specify:_____		

Very Important!!! NEW PATIENTS ONLY: Who may we thank for referring you to our office?
Friend or Relative _____ if not referred, how did you choose our office?

☐ Another Doctor	☐ Insurance list	☐ Sign / Building	☐ Website
☐ Newspaper / Radio / TV	☐ Other: _____		

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Digital Retinal Photography

Our doctors highly recommend digital retinal imaging as part of your routine eye exam. This technology combines retinal photography with computerized imaging to allow instant viewing of the retina and optic nerve in great detail. Both the doctor and the patient will see the images on a computer monitor.

This method of examining and documenting the retina promotes earlier diagnosis of abnormal conditions, which could allow us to prevent permanent vision loss. An additional benefit of retinal imaging is that we store the pictures permanently and compare them against any changes in the future.

We are very excited about the results of this new technology and highly recommend retinal imaging as an additional optional test in your eye exam. The fee is only $15, but is not cover by insurance plans.

Please let us know your preference by checking one box below:

☐ Please perform Digital Retinal Imaging as recommended.

☐ I do not wish to have Digital Retinal Imaging performed.

Patients Signature: _____

Parent or Guardian (if under 18): _____

Date: _____

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PLEASE READ AND SIGN

We will be happy to file the insurance you present at the time of service. If at a later date you find that you have another or different insurance; it will be your responsibility to file that insurance. We will provide you with a statement in order for you to file.

PRINT NAME: _____

SIGNATURE: _____

DATE: _____