Welcome to our office

SHEILA D. MERRITT, O.D.
Phone: (904)268-2299 fax: (904) 268-6867

Name____ Male / Female
Last First Middle Initial
Address________________________ City_________ State____ Zip__________
Home Phone______________________ Cell Phone_________________________
Birthdate ____________ Age_______ Work Phone_________________________
Occupation______________________ Place of Employment/School____________
If married, spouse's name____________ If child, parent's name_________________
Email address ____________________________________
If paying by check, driver's license #___________________ State_______________
Emergency contact: name____________________ phone#____________________

HIPPA (Health Information Privacy and Portability Act)**:** I have read and understand the office HIPPA policy (attached to clipboard). Signature below is only acknowledgement that I have seen and read this policy.

Patient (or guardian) signature ______________ Date__________

Vision Insurance:

I understand that verification of coverage must be done PRIOR to exam/services. Otherwise, patient will be responsible for filing for insurance benefits.

Patient signature_______________ Date __________

NOTE: We are providers for Eyemed plans. Please present card & valid ID at front desk.

Eyemed plan name_________________ Policy #____________________
Patient's Social Security#______________ Patient's DOB_______________
Responsible member (if different than patient): Name_____________________
S.S. #______________ DOB________ Employer_____________

Medical information release: I request that payment of authorized insurance be made either to me or on my behalf to Dr. Sheila Merritt for any services furnished me by that doctor. I authorize any holder of medical information about me to release to the health care administration and its agents any information needed to determine these benefits or the benefits payable for related services. Patient signature____________________ Date______________

Eye History:

Reason for today's visit__________________________ Date of last exam______________
Any special eye or vision problems____
List any previous eye injuries or surgeries____
Does your work require special vision care? Explain _______________________________
Please list hobbies/activities that may require special vision care_________________________
How did you hear about our office?____

2 .

Contact Lens Info:

Do you desire an evaluation for contacts &/or update contact Rx today? ____yes ____no

Do you currently wear contact lenses? ___ yes ___no Or have you worn them before? ___yes ___no

If yes, what kind? ___soft ___ rigid ___disposables ___monovision ___bifocal ___astigmatic(torics)

Which brands have you worn?_______________ How many years have you worn contacts?_______

Do you sleep in your contact lenses? ___yes ___no Or do you remove them nightly? ___yes ___no

What solutions do you use?_______________

Medical History:

Below are questions about your ocular and family medical history. Due to your eyes being directly *affected by your general health*, medical problems, and the medications you take, please answer *completely* so we can better care for your visual needs.

Eye conditions/symptoms ***you*** have (or have had):

Blurred vision___	cataracts___	glaucoma___	dry eyes___	floater/spots___
Double vision___	eye pain___	redness___	itching___	tearing_____
Eyelid problems___	halos___	infection___	blindness___	eye injury___
Retinal problems___	lazy eye___	flashes____	light sensitivity________	
Eye color____________			macular degeneration____	

Do ***you*** have (or have had)?

Diabetes___	High blood pressure___	Heart disease___
Headache___	High cholesterol___	Thyroid disease___
Asthma___	Lung disease___	Kidney disease___
Arthritis___	Skin disorder___	Gastrointestinal disorder___
Stroke___	Cancer___	Neurological ___
Anemia___	Seizure___	Auto Immune disease____
Hay fever___	Sinus problems___	HIV positive___

Are you pregnant or nursing? Yes_____ No_____

Are you taking any medications (including over-the-counter meds, vitamins, and herbal supplements)? ___yes ___no

Please list____

____

____

Are you allergic to any *medications*? ___yes ___no List_______________

____

Do you have allergies (seasonal, etc.)? ___yes ___no List_______________

Medical doctor_______________________ Last visit_______________

Medical doctor's phone #_______________

Does anyone in your ***family*** have any of the following medical problems?

Diabetes______ High blood pressure____ Heart disease__________

Migraines______ High cholesterol_______ Thyroid problems______

Cancer_______ Glaucoma____________ Cataracts_____________

Blindness_____ Color deficiency_______ Retinitis Pigmentosa____

Macular Degeneration __________________ Other_________________

Dilation:

Although we can determine a spectacle prescription without a dilated fundus exam, this only provides a limited view of the inside of your eye and some very serious conditions may go undetected including, but not limited to, retinal holes, tears, and detachments. Drops are placed in the eyes to enlarge the pupils. This dilation usually lasts for 2-6 hours. During this time, your eyes will be sensitive to light and your vision may be blurry, especially at near. This procedure is included in your comprehensive eye exam.

_______ I can have this procedure today.

_______ I am unable to do this procedure today and need to reschedule it.