Welcome to Dr. Faye N. Tupa, O.D., P.C.!

We want to welcome you and appreciate that you have chosen us as your family eye care provider.

This diagnostic form will help us in evaluating both your vision and total eye and body health.

Please take a few moments to complete it.

PERSONAL INFORMATION

Name: Last:___________________________________ First:________________________ M.I._______ Title:_________

Address:_______________________________________ City:_________________________ State:_______ Zip:________

Date of Birth:__________________________________ SS#:_________________________ Marital Status:____________

Home Phone: ______________________ Work Phone:______________________ Cell Phone: _____________________

Employer:_____________________________________ Occupation:____

Hobbies/Interests?____

Medical Insurance:___________________________________ Vision Insurance:__________________________________

Secondary Insurance (if applicable):____

Race: ☐ African American ☐ Asian ☐Hispanic ☐Native American ☐ White ☐ Other________

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Native American

Preferred Language:____

FOR PATIENTS FILING INSURANCE CLAIMS

We work hard to verify medical and vision insurance benefits. There are times that the benefits provided to us by the insurance company are not correct. We are not responsible for incorrect information given to us by the insurance companies such as coverage, co-pays, allowances and any other information they provide. You are responsible for any amount that is not covered or paid for by your insurance company for services or materials that are provided by Dr. Faye N. Tupa, O.D., P.C. Full payment is expected within thirty days of such notice from the date the bill was mailed.

I hereby authorize my insurance benefits be paid directly to the physician and I also authorize the physician to release any information required to process the claim.

Routine vs. Medical Exams

A **routine** exam is when there are no medical problems or diseases that affect a patient's vision. Vision plan insurance is used for this type of visit.

A **medical** exam is when a problem or disease has been identified by the physician or if the patient is experiencing pain, ongoing headaches, dry eyes or any symptom that is associated or indicative of a medical issue. Medical insurances are used for these types of exams.

Please note that a medical exam is necessary for ALL glaucoma and diabetic patients as well as any patient with medical history that directly affects the vision system.

____ ____

Patient/Guardian Signature Date

The law requires that Faye N. Tupa, O.D., P.C. make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that I was given the opportunity to read or have explained to me Faye N. Tupa, O.D., P.C.'s Notice of Privacy Practice and agree to continue my care with Faye N. Tupa, O.D., P.C. under said terms.

____ ____

Patient/Guardian Signature Date

Name: Last:____________________________________ First:________________________ M.I._______ Title:_________

OCULAR HISTORY

Are you using any eye medications, either prescribed or over the counter? ☐YES ☐NO

If YES, please explain:____

Is this your first eye exam? ☐YES ☐NO

If NO, when was your last exam and with whom? ____

Have you/family member ever been diagnosed with any of the following conditions?

Glaucoma	☐YES	☐NO	☐SELF	☐PARENTS	☐SIBLING	☐GRANDPARENT
Cataracts	☐YES	☐NO	☐SELF	☐PARENTS	☐SIBLING	☐GRANDPARENT
Macular Degeneration	☐YES	☐NO	☐SELF	☐PARENTS	☐SIBLING	☐GRANDPARENT
Retinal Detachment	☐YES	☐NO	☐SELF	☐PARENTS	☐SIBLING	☐GRANDPARENT
Crossed/Lazy Eye	☐YES	☐NO	☐SELF	☐PARENTS	☐SIBLING	☐GRANDPARENT

Primary Vision Correction:

☐ None ☐ Glasses – full time ☐ Glasses – readers only ☐ OTC Readers ☐ Contacts – soft ☐RGP's

If using contacts, what type of contact lens are you using?____

Cleaner:____ **Daily wear time:** __________hours/day

Disposal: ☐ Daily ☐Weekly ☐Monthly ☐Yearly ☐_________________________________

MEDICAL HISTORY

Many diseases of the body have serious eye health consequences. Please answer the following questions. While they may seem unrelated to an eye problem, it is crucial to your care that we ask them.

☐ None **General** ☐ Fever ☐ Weight Loss/Gain ☐ Fatigue

☐ None **Ears, Nose, Throat** ☐ Allergies ☐ Sinus ☐ Cough ☐ Dry mouth ☐ Dry throat

☐ None **Cardiovascular** ☐ HBP ☐ Heart Surgery ☐ Vascular Disease

☐ None **Respiratory** ☐ Asthma ☐ Emphysema ☐ Chronic bronchitis ☐ COPD

☐ None **Genital, Kidney, Bladder** ☐ Kidney Stones ☐ Frequent urination ☐ Impotence

☐ None **Muscles, Bones, Joints** ☐ Arthritis ☐ Joint pain ☐ Head ☐ Neck injury

☐ None **Skin** ☐ Growths ☐ Rashes ☐ Acne ☐ Eczema

☐ None **Neurological** ☐ Headaches ☐ Migraines ☐ Seizures

☐ None **Psychiatric** ☐ Depression ☐ Anxiety ☐ Insomnia

☐ None **Endocrine** ☐ Thyroid ☐ Diabetes

If diabetic: Last A1C_____________ Date taken___________________ Last Glucometry____________

☐ None **Blood/Lymph** ☐ Anemia ☐ Cholesterol ☐ Bleeding problems

☐ None **Allergic/ Immunologic** ☐ Seasonal allergies ☐ Rheumatoid ☐ MS ☐ Lupus ☐ HIV

☐ None **Gastrointestinal** ☐ Diarrhea ☐ Constipation ☐ Ulcers ☐ Acid reflux

PLEASE COMPLETE THE OTHER SIDE

Primary Care Physician (or Clinic):__________________________________ Date of last visit:_________________________

Reason for last visit: ☐ Check-up ☐ Physical ☐ RX refill ☐ Other:________________________________

Medications (including over the counter)

____

____

____

☐ NKDA Allergies to Medicine:____

Have you ever had any surgery or been hospitalized? ☐YES ☐NO

If YES, please explain:____

____

____

Females Are you pregnant? ☐YES ☐NO Are you nursing? ☐YES ☐NO

Have you had a recent tetanus shot? ☐YES ☐NO

Do any medical diseases run in your family (blood relatives)? Please indicate who.

☐ ADOPTED

Diabetes	☐YES	☐NO	☐PARENTS	☐SIBLING	☐GRANDPARENT
HBP	☐YES	☐NO	☐PARENTS	☐SIBLING	☐GRANDPARENT
Stroke	☐YES	☐NO	☐PARENTS	☐SIBLING	☐GRANDPARENT
Cancer	☐YES	☐NO	☐PARENTS	☐SIBLING	☐GRANDPARENT
Thyroid	☐YES	☐NO	☐PARENTS	☐SIBLING	☐GRANDPARENT

Do you smoke? ☐ Never smoked ☐ Former smoker ☐ Current smoker

Do you drink alcohol? ☐ No ☐ Occasionally ☐ 1/day ☐ 2-3/day ☐ 4+/day

Do you use illegal drugs? ☐YES ☐NO

PUPIL DILATION

We believe dilation is an important part of your exam, but we also understand and respect your desire to make informed decisions about your own healthcare. Sometimes you may need an exam, but dilation might not fit into your plans. We understand. At your visit you may choose not to be dilated.

The most important thing is that our patients understand the benefits and risks of not being dilated. Without dilating the pupils your doctor is not able to fully evaluate the health of the back of the eye. Pupil dilation allows your doctor to inspect your entire retina, the optic nerves, macula, and the blood vessels.

Would you like your eyes to be dilated? ☐YES ☐NO ☐IF NEEDED