

WELCOME TO DELTAVISION

OFFICE OF DR. GREG POPOWITZ

Patient's Name _____

If minor, who is responsible for patient? _____ Relationship _____

Address _____ City _____ Zip Code _____ Home Phone _____

Work or Cell Phone _____ Date of Birth _____ Age _____ Male/Female _____

Vision Insurance _____ Employer _____

Insured's Name _____ ID# _____ Date of Birth _____

Other Vision Insurance _____

Medical Insurance _____ ID# _____

Primary Care Physician Name and Telephone Number _____

PAYMENT AUTHORIZATION

I hereby authorize payment of my vision/medical benefits to Deltavision Optical. I understand that I am responsible for any charges not covered by my benefit plan. I grant permission for Deltavision Optical to release information from my case records.

Signature _____ Date _____

HEALTH HISTORY

Medications Used: _____

Known Drug Allergies: _____ How long ago since your last exam? _____

Please circle any of the following that apply.

High Blood Pressure Diabetes Asthma Allergies Headaches _____
(Please Describe)

See Flashes of Light Eye Injury HIV Glaucoma Eye Surgery _____
(Please Describe)

See Spots or Floaters Eye Itchiness Stroke Thyroid Eye Disease _____
(Please Describe)

Are you Pregnant? _____ Months _____

FAMILY HISTORY

(Please circle any of the following that apply)

Diabetes Glaucoma Macular Degeneration Other _____

ARE YOU INTERESTED IN ANY OF THE FOLLOWING

Laser Surgery Prescription Sunglasses Computer Glasses
CONTACT LENSES: Disposable Color Bifocal Gas Permeable Hard

DO YOU HAVE PROBLEMS WITH ANY OF THE FOLLOWING

Blurry Distance Vision Reading Problems Glare or Reflections Night Driving
Sensitivity to Light Watery or Dry Eyes Computer Strain Double Vision

Medical History Questionnaire

Name _____ Date _____

Date of Birth _____	Date of last eye exam _____
List any medications you currently take (Rx and over-the counter): _____ _____	
Do you have allergies to any medication? YES NO	
If YES, list the medications: _____	
List all major illnesses (glaucoma, diabetes, high blood pressure, heart attack, etc.) or injuries (concussion, etc.): _____ _____	
List any surgeries you have had (cataract, appendectomy): _____	

Do you currently have any problems in the following areas? If YES, Please provide additional information:

	YES	NO	Details
EYES (poor vision, eye pain, tearing, redness, etc.)			
GENERAL / CONSTITUTIONAL (fever, heat stroke, weight loss, weight gain, unusually tired)			
EARS, NOSE, THROAT (hard of hearing, stuffy nose, ear ache, cough, dry mouth, etc.)			
CARDIOVASCULAR (high BP, racing pulse, etc.)			
RESPIRATORY (congestion, wheezing, short of breath, etc.)			
GASTROINTESTINAL (stomach upset, diarrhea, constipation, hernia, ulcers, etc.)			
GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, impotence, yellow jaundice, etc.)			
FEMALES Are you pregnant? Nursing?			
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, arthritis, etc.)			
SKIN (pimples, warts, growths, rash, etc.)			
NEUROLOGICAL (numbness, headaches, seizures, paralysis, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia)			
ENDOCRINE (diabetes, hypothyroid, etc.)			
BLOOD / LYMPH (bleeding, cholesterolemia, anemia, problems related to blood transfusion, etc.)			
ALLERGIC / IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, etc.)			

FAMILY HISTORY (Mother, Father, Grandparent, Sibling)

Has any member of your family had these diseases (circle all that apply)? Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis Other heritable disease: _____
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SOCIAL HISTORY

Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)? Have you ever had a blood transfusion?.....YES NO Do you drink alcohol?.....YES NO If YES, how much? _____ Do you smoke?.....YES NO If YES, how much? _____ How many years? _____
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Physician's Signature _____ Date _____

HIPPA COMPLIANCE ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I have received / reviewed a copy of NOTICE of
PRIVACY PRATICES.

Patient's Name _____

Signature _____

Date _____

DELTAVISION FEES

COMPREHENSIVE EXAMINATION *	\$79.00
CONTINUING LENS WEAR EVALUATION WITHOUT FOLLOW-UP*	\$30.00
STANDARD CONTACT FITTING*	\$60.00
SPECIALTY CONTACT FITTING * -BIFOCAL OR MONOVISION	\$90.00
CONTACT LENS TRAINING (CL CLASS)	\$20.00

*STANDARD AND SPECIALTY FITTINGS INCLUDE FOLLOW-UP CARE VISITS FOR 30 DAYS
FROM THE EXAM DATE.

- ALL FITTINGS MUST BE COMPLETED WITHIN 30 DAYS OF INITIAL EXAM DATE
- A \$55.00 OFFICE VISIT CHARGE WILL APPLY IF FOLLOW UP VISIT IS NOT COMPLETED
- ALL FEES ARE NON-REFUNDABLE AND SUBJECT TO CHANGE
- ALL RETURNS SUBJECT TO 20% RESTOCKING AND SHIPPING FEE
- MEDICAL FEES ARE SEPARATE AND NOT PART OF A COMPREHENSIVE EYE EXAM

I understand that the above charges are part of Deltavision Optical fees and that I am responsible for any expenses
not covered by my insurance.

Patient
Signature _____