



Welcomes You Back!

Name _____ Date _____
(First) (MI) (Last)

Age _____ E-mail address _____

Occupation _____ Employer _____

Have you had a change of address or phone number since your last visit? Yes No
If yes, please provide us with your new information.

Address _____ Apt. # _____
City _____ State _____ Zip _____
Phone _____ Cell phone _____

Dr. Starling routinely dilates patients at every comprehensive examination. If you have any questions or concerns regarding this, please let us know and we will be happy to assist you.

In the past 7-10 days have you experienced any of the following? (please check all that apply)

- | | | | |
|---|--|------------------------------------|--|
| <input type="checkbox"/> Loss of vision | <input type="checkbox"/> Double vision | <input type="checkbox"/> Mattering | <input type="checkbox"/> Excessive light sensitivity |
| <input type="checkbox"/> Tearing | <input type="checkbox"/> Floaters | <input type="checkbox"/> Burning | <input type="checkbox"/> Blurry vision |
| <input type="checkbox"/> Redness | <input type="checkbox"/> Headache | <input type="checkbox"/> Itching | <input type="checkbox"/> Flashing lights |

Health History: Check all that apply or check here if nothing has changed since your last visit

Constitution:

- Developmental disability
- Cancer
- Fatigue Syndrome

ENT:

- Hearing Loss
- Dry mouth
- Sinusitis
- Laryngitis

Neurological:

- Cerebral Palsy
- Multiple Sclerosis
- Tumor
- Epilepsy

Psychological:

- Depression
- Other

Cardiovascular:

- Heart disease
- Stroke
- Vascular disease
- Congestive heart failure
- High blood pressure

Respiratory:

- Emphysema
- Smoker
- COPD
- Bronchitis

GI:

- Chron's disease
- Ulcer
- Colitis

Genito-urinary:

- Kidney
- STD (herpes/Chlamydia)
- Prostate disease/cancer

Musculo-skeletal:

- Muscular dystrophy
- Osteoarthritis
- Fibromyalgia
- Ankylosing spondilitis
- Arthritis

Integumentary:

- Psoriasis
- Eczema
- Rosacea

Endocrine:

- Hormonal dysfunction
- Insulin dependent diabetes
- Thyroid dysfunction
- Non-insulin diabetes

Hematology/Lymphatic

- Ulcer
- Anemia
- High Cholesterol
- Large volume blood loss

Allergy/Immunology:

- Environmental

- Lupus

- Rheumatoid Arthritis



Welcomes You Back!

☐ Please list all current medications you are taking (including eyedrops):

☐ Do you currently take: (please check any that are applicable)

___ Plaquenil ___ Tamoxifen ___ Accutane ___ Herbal supplements

☐ Please list all allergies to medications:

Previous ocular history: Please check all that apply or check here if there are no changes ☐

___ Glaucoma ___ Cataract ___ Macular degeneration ___ Injury
___ Strabismus ___ Patching ___ Inflammatory disorder ___ Surgery
___ Glaucoma suspect ___ Amblyopia ___ Retinal hole/tear/detachment ___ Other

Family history: Please check all that apply or check here if there are no changes since last visit ☐

___ High blood pressure ___ Thyroid disease ___ Diabetes ___ Cancer

Family ocular history: Please check all that apply or check here if there are no changes ☐

___ Amblyopia ___ Strabismus ___ Glaucoma ___ Severe Myopia
___ Retinal detachment ___ Severe Hyperopia ___ Cataract ___ Glaucoma suspect

☐ Do you smoke? (if yes, please indicate how many packs per day)

☐ Do you drink more than 4 alcoholic drinks per week?

☐ Are you currently pregnant?

☐ If you currently wear contact lenses please list the type of contact lenses you wear:

How often do you replace your lenses?

How many hours per day do you wear contact lenses?

What type of solution do you use?

Do you sleep in your contact lenses?

☐ Are you interested in getting new glasses at your visit today?

☐ Are you interested in getting a prescription for contact lenses at your visit today?

☐ Do you have any other concerns you would like addressed at your visit today?

Office Policies

☐ Patients under the age of 18 can not be examined unless accompanied by a parent or guardian.

☐ Eyeglass prescriptions will be rechecked as a courtesy for a period of 3 months at no charge. After this 3 month grace period expires, office charges will apply.

☐ All contact lens exams include 3 months of follow-up care. If lenses are not picked up within this time frame or follow-ups are not completed, a new exam will be required to release the prescription.

☐ In accordance with Florida Laws and Rules, section 59V-3.007, all patients will be tested for glaucoma as part of the routine exam. No exceptions will be made to this policy.

☐ Payment is due at the time services are rendered. You will be held financially responsible for any fees not covered by insurance programs. Professional fees are non-refundable.

☐ Insurance or discount programs must be presented at the time of service, or can not be accepted.

☐ By signing below, you authorize Starling Eye Group to submit insurance benefits on your behalf and release any medical information that may be necessary to process your claim. Once they are submitted, no adjustments may be made. Patients are responsible for understanding their insurance benefits.

Patient signature: _____

(or parent if patient is under the age of 18)