Allergic/Immunologic
- ❑ None
- ❑ Lupus (SLE)
- ❑ Rheumatoid Arthritis
- ❑ Environmental Allergies
- ❑ Seasonal Allergies
- ❑ Other (i.e., Latex)

Ear, Nose and Throat
- ❑ None
- ❑ Sinusitis
- ❑ Upper Respiratory Tract Infection
- ❑ Other

Gastrointestinal
- ❑ None
- ❑ Crohn's Disease
- ❑ Colitis
- ❑ Acid Reflux/Ulcer
- ❑ Other

Skin/Integumentary
- ❑ None
- ❑ Eczema
- ❑ Rosacea
- ❑ Psoriasis
- ❑ Other

Psychiatric
- ❑ None
- ❑ Depression
- ❑ Bi-Polar
- ❑ Schizophrenia
- ❑ Other

Cardiovascular
- ❑ None
- ❑ High Blood Pressure
- ❑ Heart Disease
- ❑ Stroke
- ❑ Vascular Disease
- ❑ High Blood Cholesterol

Endocrine/Glands
- ❑ None
- ❑ Diabetes
- ❑ Hormone Dysfunction
- ❑ Thyroid Dysfunction
- ❑ Other

Respiratory
- ❑ None
- ❑ Asthma
- ❑ Bronchitis
- ❑ Emphysema
- ❑ Other

Muscle/Skeletal
- ❑ None
- ❑ Arthritis
- ❑ Fibromyalgia
- ❑ Ankylosing Spondylitis
- ❑ Other

Genital/Urinary
- ❑ None
- ❑ Urinary Tract Infection
- ❑ HIV Positive
- ❑ Herpes/Chlamydia
- ❑ Other

Hematologic/Lymphatic
- ❑ None
- ❑ Anemia
- ❑ Leukemia
- ❑ Bleeding Disorder
- ❑ Other

Neurological
- ❑ None
- ❑ Multiple Sclerosis
- ❑ Epilepsy
- ❑ Tremors
- ❑ Other

General Health
- ❑ None
- ❑ Weight Loss/Gain
- ❑ Fever
- ❑ Fatigue
- ❑ Trauma

Social

Tobacco Use:
- ❑ Current Smoker
- ❑ Former Smoker
- ❑ Non-Prescription_____
- ❑ Alcohol Consumption_____

Financial Responsibility Statement:

I agree to provide all necessary information for Today's Vision to obtain authorization for my insurance carrier _____.
I agree to be financially responsible for all charges incurred by me or my dependents that are not paid by my insurance plan.
Patient/Guardian Signature _____ Date_____

Notice of Privacy Practices:

_____ I acknowledge that I have read a copy of the Today's Vision Notice of Privacy Practices.
_____ I consent to the policies contained in the Today's Vision Notice of Privacy Practices.

Extended Privacy Consent:

_____ I agree to extend my privacy consent to cover the following circumstances: persons over the age of 18 still under their parents household (consent to share information with parents), adults consenting to share information with spouse and personal patient data in forms needing filled out for work, DPS forms, school screenings or any form not considered part of the routine prescription or patient chart.

_____ Knowing that standard email and text communication may not be totally secure, I still consent to communications from my doctor or staff through my standard email and text devices. Any information sent to a third party must be sent through said party's encrypted email, fax or written mail as no standard email is authorization according to HIPAA regulations.

EYECON VS. DIALATION

We believe checking your eye health is just as important as your vision! Many health problems such as glaucoma, cataracts, diabetes, and tumors can be detected even before the onset of symptoms or loss of vision. We provide 2 different options for you to choose from in order to assess your ocular health.

Please select one

☐ **Dilation**: A great way to open your pupils for the doctor to have a better view of the inside of your eyes. *Causes light sensitivity and blurry vision for about 4 hours. Included as part of your routine eye exam.*

☐ **EyeCon:** Don't like eye drops? Don't want blurry vision for 4 hours? The EyeCon is a fast and educational way to evaluate the inside of your eyes. It also provides a permanent record for your file. *Additional **$39 fee**. Not covered by insurance*

If you are uncertain about which is the best option for you, no need to worry. Our doctor will go over these options in greater detail with you to help you select the best option for your eye health.

Patient/Guardian Signature: _____ Date: _____