ARKANSAS EYE SITE

ANNUAL FORM

Date: _____

Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Primary Care Physician: _____ Pharmacy: _____

1.) Since your last visit to our office, have you developed any new allergies or had a bad reaction to a medication or food?
Yes No

If yes, describe: _____

2.) Since your last visit to our office, have you had any new diagnosis or medical problems?
Yes No

If yes, describe: _____

3.) Please provide us with an updated list of your medications.

_____

_____

4.) Would you like to make any changes to your HIPAA release of information?
Yes No

If yes, describe: _____

5.) Would you like to make any changes to your Assignment of Benefits (insurance information)?
Yes No

If yes, describe: _____

6.) Do you want to be checked for a new glasses/contact lens prescription today?
__If you DO NOT have a Vision Insurance**__, there will be a $20.00 fee due today**
(Medical insurances do not cover this fee)
Yes No

Signature of Patient or Legal Guardian: _____Date: _____

Optos Retinal Imaging Information

Our Optomap technology gives your eye doctor a comprehensive view of your retina, which helps in spotting signs of diseases at their earliest stages. By viewing most of the retina at once, your eye doctor can spend more time explaining the images and discussing your eye health with you.

Optomap is recognized in numerous clinical studies as a valuable diagnostic tool. Starting January 1, 2024, we will include this technology in our regular exams as a part of our commitment to high-quality care. We take yearly photos to assist your doctor in monitoring your retinal health and to keep a digital record for future comparison.

THIS TEST IS NOT COVERED BY INSURANCE

Service Fee: $25.00

___YES, I would like to receive this service.

___NO, I would NOT like to receive this service

Patient Signature: _____

Date: _____

Lifestyle Index

PT INITIALS / ID _____

DATE _____

This questionnaire is meant to help your doctor understand what you're experiencing on a regular basis — whether it's caused by your eyes, posture, stress, etc. Your responses will help make sure you receive the best care possible.

How often do you experience any of these symptoms? Fill in applicable circle. For example: 1 2 3 4 5 (3 filled)

Headaches
of any severity each week, usually getting worse later in the day

1 Never ○ | 2 Rarely ○ | 3 Sometimes ○ | 4 Very Often ○ | 5 Always ○

Stiffness / pain in neck / shoulders
when you work at a computer or read

1 Never ○ | 2 Rarely ○ | 3 Sometimes ○ | 4 Very Often ○ | 5 Always ○

Discomfort with Computer Use
in your eyes (redness, burning) after long hours looking at the screen

1 Never ○ | 2 Rarely ○ | 3 Sometimes ○ | 4 Very Often ○ | 5 Always ○

Tired Eyes
with increasing feeling of eye fatigue throughout the day

1 Never ○ | 2 Rarely ○ | 3 Sometimes ○ | 4 Very Often ○ | 5 Always ○

Dry Eye Sensation
feeling progressively more gritty/sandy while working at computer or reading

1 Never ○ | 2 Rarely ○ | 3 Sometimes ○ | 4 Very Often ○ | 5 Always ○

Light Sensitivity
especially with brighter, stronger lights like fluorescents or headlights

1 Never ○ | 2 Rarely ○ | 3 Sometimes ○ | 4 Very Often ○ | 5 Always ○

Motion Sickness
or an experience like dizziness or vertigo

1 Never ○ | 2 Rarely ○ | 3 Sometimes ○ | 4 Very Often ○ | 5 Always ○

FOR OFFICE USE

Neurolens Value	Prism Split for Order Entry	Misalignment	Mono PD	MQI	AC/A Ratio
	OD:	Near:	OD:	Near:	
	OS:	Distance:	OS:	Distance:	