HESTER OPHTHALMOLOGY

Patient Name: _____ **Date of Birth:** _____

Since your last visit with Dr. Hester…

Please list any changes to your Address: _____

Phone number(s) & email address: _____

List any changes to your Emergency Contact information: Name: _____

Relationship: _____ Address: _____

Phone number(s) & email address: _____

Any New Doctors? Primary Care: _____ Optometrist: _____

Other Physicians: _____

Describe any significant health events, surgeries or procedures since your last visit: _____

_____

Eye symptoms:

Has your vision become worse since your last visit: ☐ Yes ☐ No

Are you experiencing glare symptoms from sunlight or from headlights at night? ☐ Yes ☐ No

Do you have more difficulty reading since you were last seen (with your glasses, if applicable)? ☐ Yes ☐ No

Do you have more difficulty seeing your television (with your glasses, if applicable)? ☐ Yes ☐ No

Are you having more difficulty seeing objects at a distance or following a golf /tennis ball when playing? ☐ Yes ☐ No

Do you find that you need to get closer to traffic signs in order to read them? ☐ Yes ☐ No

Are you experiencing any of the following?

☐ eye pain ☐ watering ☐ burning ☐ itching ☐ new floaters ☐ double vision

Changes to Medications or allergies: ☐ I have a separate list with me (*or* list below)

Name	Dosage	Name	Dosage
_____	_____	_____	_____
_____	_____	_____	_____

List any other health symptoms you are having now or within the past 30 days: _____

_____

I hereby authorize payments of medical and surgical benefits to Hester Ophthalmology, PC as applicable. I understand that I am financially responsible for any charge whether or not paid by my insurance. I understand that some services, including refractions, are not covered by some insurance plans or by Medicare and that I am responsible for payment at the time those services are rendered. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Hester Ophthalmology, PC as applicable. I authorize the release of any information required to process any and all claims for reimbursement on my behalf or to treat my condition. I understand that co-payments are due at the time of service.

Patient Signature: _____ **Date:** _____