Welcome To Dr. Paul Johnson's Office
(Please Print Clearly)

Patient's Name:_____ Birthday: ____/____/_____

DILATION

The dilated eye exam is an additional procedure using eye drops and specialized instruments to get the most extensive evaluation of the internal eye structures. Many eye disorders have no symptoms or early warning signs. With dilation beginning problems can be detected and prevent much earlier. An eye exam cannot be considered a complete exam without dilation. The doctor strongly recommends dilation for the highest standard of care, especially if any of the following apply:

-High Blood Pressure -Frequent or Severe Headaches -Diabetes - Cataracts -Unusual Changes in Vision
-High Nearsightedness -Symptoms of flashes or Floaters - Personal or Family History of Glaucoma

Many people don't wish to have dilation due to blurring of near vision and light sensitivity that may last 4 to 6 hours.
We use new milder drops that can wear off faster.

****There is no additional cost for dilation****

Please Check One:

☐ I **wish** to have dilation done today ☐ I **do not** wish to have dilation today ☐ Only if the doctor finds it necessary

Patient Signature: _____ Date: _____
If patient is a minor (under 18 years old), the parent/guardian MUST sign this form

CONTACT LENS FITTING/RENEWAL AGREEMENT *PLEASE SIGN AND DATE AFTER READING BELOW*

*****NOTE all contact lens exams MUST be done within 30 days from today's date of service.***
If you mark "NO" a prescription will NOT be given to you today nor will any trials**

Would you like a Contact Lens Prescription today? YES ☐ NO☐

Contact lens prescriptions expire one year after the date of the initial exam. Examination and fitting fee covers professional services only, and do not include the cost of any materials or supplies. Most patients successfully wear contact lenses, but a successful fit and wearing experience cannot be guaranteed. No professional fees will be refunded. **Contact lens fitting for the prescription can range from $55 to $350 depending on your visual needs** (this does NOT include any contact lenses).

New patients *or* those who are fit in a different contact lens **must have a follow-up visit**, verifying the safety and effectiveness of the contact lenses, before the contact lens prescription will be finalized. Two contact lens follow-up visits are included for the first 30 days after the date of the exam. **If you have not had your contact lens prescription finalized within these 30 days, each follow-up will include a refraction fee of $55 and the fitting fee.** If 90 days have expired since the date of the exam, no follow-up visits will be given to finalize or change the prescription, and a new exam will be required.

New patients will be required to do a training with one of our staff members to make sure you know how to properly put on and take off the contact lenses. We do not allow you to take the trials home without this training, unless you, the patient, have worn contacts in the past. The training will be $25 per session.

REFUNDS

There will be **NO** refund of the exam, fitting, annual contact lens check fees, boxes of lenses, custom lenses or colored lenses.

Most insurance companies do NOT cover contact lens evaluation/fitting fees or training.
Our doctor or staff would be happy to answer any questions you may have.

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Please turn this page over and continue

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Personal Medical History	YES	NO	If yes, please describe/Medication
Diabetes			
High Blood Pressure			
High Cholesterol			
Thyroid			
Asthma			
Headaches/Migraines			
Blurred Vision			
Lazy Eye			
Eye Strain			
Double Vision			
Eye Injury			
Eye Surgery			
Flashes of Light			
Floaters in Vision			
Cataracts			
Retinal Disease			
Glaucoma			
Drooping Eyes			
Excess Tearing			
Foreign Body Sensation			
Burning			
Itching			
Family Medical History	**Yes**	**No**	**If yes, please provide which family member:**
Lazy Eye			
Blindness			
Cataracts			
Glaucoma			
Diabetes			
High Blood Pressure			
High Cholesterol			
Crossed Eye			
Macular Degeneration			
Retinal Detachment			
Heart Disease			
Thyroid			
Other			

Do You Wear:

Glasses ____Yes ____No
If yes, when do you wear glasses?
(Circle all that apply below)

A. Seldom
B. Always
C. While Watching TV
D. While Reading
E. While Driving
F. While on the computer

How old are the lenses in your current frames? _____
How long are you on the computer?_____ hours per day
Contacts _____ YES ____ NO
IF NO PLEASE SKIP TO SOCIAL HISTORY
If yes,: Type:_____
Hours per day: _____
Do you sleep in your contacts?
_____ Yes _____ No
How old are your present pair of lenses? _____
Are they comfortable? ___Yes ___No
What time do you put them on?_____
What time do you take them off?____

Social History
(THIS HELPS US EVALUATE YOUR VISION COMPLAINTS)
Do you use:
Tobacco products? ____ Yes ___No
Alcohol? ____Yes ___No
Cannabis products? ____Yes ___No
Illegal Drugs? ____Yes ___No

Were you interested in Lasic Surgery?
___Yes ____No
Do you drive? ___Yes ____No
If yes,do you have any visual difficulty when driving?___Yes __No
If yes, explain,:_____
_____
_____

If female, are you pregnant?
_____Yes ____No

Patient Signature: _____ **Date:** _____
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PRIVACY POLICY AND HIPAA

Patient Printed Name:_____

Please list below the name(s) of any person(s) that we may give any of your information to:

****If left blank, you and you alone are the only person who may pick up copies of prescriptions, receipts or any medical devices****

Name:_____ Date of birth:_____

Name:_____ Date of birth:_____

Name:_____ Date of birth:_____

Please list below the name of your Primary Care Physician that we may give any of your information to:

Name:_____ Their Phone #:_____

Name:_____ Their Phone #:_____

Patient Signature:_____ Date:_____

If patient is a minor (under 18 years old), the parent/guardian MUST sign this form

INITIAL below if you would like a copy of Dr. Johnson's Notice of Privacy Practices:

_____ Yes, I would like a copy of Paul S. Johnson's Notice of Privacy Practices.

_____ No, I do not wish to receive a copy of Paul S. Johnson's Notice of Privacy Practices.

NO SHOW/CANCELLATION POLICY/ADDITIONAL COPIES RX

If you fail to provide 48 hours (Monday through Friday) notice for cancellation/reschedule/no show, the fee will be $25 per person scheduled. Three cancellations/reschedules/no shows will result in dismissal from our office. Effective January 01, 2020.

Service fee of $25 will apply at the discretion of the doctor when additional services are rendered this includes but is not limited to giving additional trials, additional copies of Rx, and release of records.

Patient Signature:_____ Date:_____

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