The Spec Shoppe, Inc.
1713 S Main St., Maryville, MO 64468
Ph. 660-582-8911
Fax 660-582-2545

Name _____ Phone _____

Address _____ Date of Last Exam _____

City, State, Zip _____ Date of Birth _____

Eye Insurance _____ Insurance Number _____

Name on Insurance _____ Social Security Number _____

Contact Lens Brand & Power _____

Reason for Todays Visit _____

Medication List _____

Allergies _____

Please check any condition that applies to yourself or any members of your immediate family: S - Self F- Family

Medical History:	S	F
Cancer	☐	☐
Diabetes	☐	☐
Headaches	☐	☐
Heart Problems	☐	☐
High Blood Pressure	☐	☐
Respiratory Problems	☐	☐
Thyroid Problems	☐	☐

Ocular History:	S	F
Blindness	☐	☐
Cataract	☐	☐
Double Vision	☐	☐
Glaucoma	☐	☐
Lazy Eye	☐	☐
Retinal Detachment	☐	☐
Eye Surgery	☐	☐
Eye Injury	☐	☐

PATIENT CONSENT

By signing below, I hereby acknowledge, agree, and authorize all of the following:

- Accurate Information: I certify that the information provided on this form is accurate, complete, and up to date to the best of my knowledge.
- Patient Rights and Responsibilities: I understand that the healthcare facility maintains a Notice of Privacy Practices, which describes how my protected health information may be used and disclosed and how I may access my health records. I understand that I have the right to review this healthcare facility's Notice of Privacy Practices prior to signing this form.
- Release of Medical Information: I authorize the release of my health information to the healthcare facility in accordance with the healthcare facilities Notice of Private Practices this includes, but not limited to, releasing medical information to my referring physician, primary care physician and any physician(s) I may be referred to. The healthcare facility shall ensure all health information remains confidential, as required by HIPPA, and will not release any of my health information without my consent.
- Consent for Treatment: I grant the healthcare facility, including its affiliated providers, physicians, and other medical personnel, permission to use my health information provided for the purpose of my medical treatment as necessary.
- Consent to Communication: I consent to receiving communications from the healthcare facility regarding appointment reminders, test results and other necessary healthcare-related information via phone, email, or channels.
- Acknowledgment: By signing below, I hereby acknowledge, agree, and authorize all of the above, and I authorize the healthcare facility to retrieve and review my medical history and authorize the healthcare facility to release the information required in obtaining procedure authorization or the processing of any insurance claims.

I understand that I am undergoing a Telemedicine* eye examination today to obtain an eyeglass, and possibly a contact lens, prescription.
Although my technician will attempt to capture images of the back of my eye and images of the front of my eye, I acknowledge that this examination may not be as comprehensive as an in person visit.
I understand that it is my responsibility to schedule a follow-up appointment with a live doctor for a more thorough examination which includes:
·Eye dilation which allows the doctor to see a higher percentage (up to 100%) of the back of my eye.
·A detailed examination of the front of my eyes using a microscope.
*Telemedicine involves the exchange of medical information from one location to another using electronic communication. This may include wireless tools, email, two-way video, smartphone, and other methods of telecommunication technology.

Signature: _____ **Date:** _____

Printed Name: _____

SUMMIT EYE CARE

Current RX	
OD	
OS	

Aided VA Dist.	OD	20/
	OS	20/
	OU	20/
Unaided VA Dist.	OD	20/
	OS	20/
	OU	20/

Pupils	PERRL	YES	NO
Motility (H)	OD:	FROM:	LIMITATION:
	OS:	FROM:	LIMITATION:
VF Screening C	OD:	FTFC:	LIMITATION:
	OS:	FTFC:	LIMITATION:
DPA's Used	DPAS	Dilation Declined	

Icare Tonometry	OD:
	OS: