

**Charlotte Optometric Eye Clinic  
Dr. Tammy Hawks**

**Patient Information Sheet (please print)**

Today's Date \_\_\_\_\_ E-Mail Address \_\_\_\_\_  
Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Telephone (H) \_\_\_\_\_ (W) \_\_\_\_\_  
SSN \_\_\_\_\_ Date of Birth \_\_\_\_\_ M/F \_\_\_\_\_  
Occupation \_\_\_\_\_ School \_\_\_\_\_  
Emergency Contact \_\_\_\_\_ Telephone number \_\_\_\_\_  
Date of last eye exam \_\_\_\_\_

**Medical Information**

Medication presently taking \_\_\_\_\_  
Tobacco Use? \_\_\_\_\_ Alcohol Use? \_\_\_\_\_  
Primary Care Physician \_\_\_\_\_ Telephone number \_\_\_\_\_  
Allergies/Medications \_\_\_\_\_  
Please circle if you have/had any of the following:  
Cataracts Glaucoma Retinal Detachment Eye Disease Eye Surgery  
Diabetes High Blood Pressure Heart Problems Convulsions/Epilepsy Thyroid  
Problem Headaches Double Vision Eye Injury Flashes of Light Head Trauma  
Watery Eyes Burning Eyes Itchy Eyes Eye Pain

**Family History**

Cataracts Glaucoma Retinal Detachment Eye Disease Eye Surgery  
Diabetes High Blood Pressure Heart Problems Convulsion/Epilepsy Thyroid

**Personal Information**

Reason for coming in today \_\_\_\_\_  
Are you interested in wearing contacts? \_\_\_\_\_  
Type of Contacts you have tried? \_\_\_\_\_  
Whom may we thank for referring you to us \_\_\_\_\_  
Are you interested in Laser Surgery? \_\_\_\_\_

**DILATION CONSENT**

Dilation of the pupil is important for the thorough evaluation of the peripheral retina. Due to the widening of the pupil, light sensitivity and difficulty with focusing at near will last at least four hours. If this presents a problem for you, dilation can be rescheduled for a more convenient time. There is no extra charge for this service.

I ACCEPT DILATION \_\_\_\_\_ I DECLINE DILATION \_\_\_\_\_

I WOULD PREFER TO RESCHEDULE DILATION \_\_\_\_\_

SIGNED: \_\_\_\_\_ DATE: \_\_\_\_\_

**CONTACT LENS EVALUATION**

If you are planning to receive contact lens you must have a contact lens evaluation every year. Many managed care insurance plans do not cover the contact lens evaluation. It is your responsibility to pay for this service (\$70.00 to \$95.00). I understand that I am responsible for this fee.

SIGNED: \_\_\_\_\_ DATE: \_\_\_\_\_

**SIGNATURE ON FILE, (MEDICARE)**

Patient's or authorized person's signature: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below:

SIGNED: \_\_\_\_\_ DATE: \_\_\_\_\_

**SIGNATURE ON FILE, (OTHER INSURANCE PLANS) Insured or authorized person's signature: I authorize payment of medical and /or material benefits to the undersigned physician or supplier for services described. I understand that filing of insurance is a service only, and is not a guarantee of payment. I understand that I am financially responsible for charges not covered by my insurance.**

Signed \_\_\_\_\_ DATE: \_\_\_\_\_