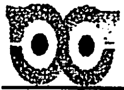

Dr. Cynthia G. Phelps, O.D.
Therapeutic Optometrist
1321 N. Loop 1604 E. Ste. 100A
San Antonio, TX 78232
VisionTech 20/20 (p) 210-782-8205
(f) 210-545-2147

Patient Information Form

Cynthia G. Phelps, O.D., P.A.
& Associates
Doctors of Optometry

DATE: ____________________

________________________________ Parent/Guardian ________________
Last Name First Name MI

DOB ________ M/F Occupation/Grade ____________________ Pharmacy: ____________

Employer ________________ SSN # ____________ Email: ____________

Home # ________________ Work # ____________ Cell # ____________

Mailing Address ________________ Apt# ______ City ____________ State ______ Zip ______

Referred by: ________________ Date of Last Exam ________________

Have you ever worn contacts? Yes / No What type? (Disposable, Gas Perm, Toric, Bifocal, Daily Wear, Colored)
Are you interested in Lasik surgery or Refractive surgery? Yes / No

PLEASE CIRCLE AS NEEDED BELOW

General Health	Patient		In Family
Diabetes	Y	N	Y or N
High Blood Pressure	Y	N	Y or N
Heart Problems	Y	N	Y or N
Lung Problems	Y	N	Y or N
Kidney Problems	Y	N	Y or N
Thyroid Problems	Y	N	Y or N
Arthritis	Y	N	Y or N
Major Operations	Y	N	
Medical Allergies	Y	N	See below
Presently Pregnant	Y	N	

Eye History	Patient		In Family
Glaucoma	Y	N	Y or N
Cataract	Y	N	Y or N
"Lazy Eye"	Y	N	Y or N
Eye Injury	Y	N	Y or N
Eye Surgery	Y	N	Y or N
Eye Diseases:			

Current Vision Problems *	
Blur @ Dist. w/o glasses	Y or N
Blur @ Dist. w/glasses	Y or N
Blur @ Near w/o glasses	Y or N
Seeing Double	Y or N
Seeing 'flashing lights'	Y or N
Eyes burn, itch, or tear	Y or N
Problems seeing @ night	Y or N
Frequent Headaches	Y or N

* Allergies ________________________________ Smoker: Yes or NO

* Medications Currently Being Taken ________________________________

Vitamins or Supplements: ________________________________

VISUAL FIELD SCREENING ANALYSIS

The visual field test evaluates your vision for areas of sight loss both in the central and peripheral field. This highly sophisticated computerized instrument assists the doctor in early detection of glaucoma, retinal disease, and some neurological disorders such a tumors and optic nerve disease. Unfortunately, an individual does not notice visual field defects until very late stages and many defects cannot be detected by the doctor simply looking into your eyes. Early detection significantly increases the chance of successfully treating the disorder. **There is an additional charge of $20 for the Visual Field test.**

☐ I would like the visual field test at an additional charge of $20. ☐ I decline the visual field test.

AS A COURTESY, WE WILL FILE MOST INSURANCE CLAIMS WHEN YOU COMPLETE THE SECTION BELOW AND PROVIDE THE FOLLOWING:

* Primary Medical Insurance: ________________________ Phone#: ____________

In order to better serve our patients if you present with a <u>MEDICAL CONDITION</u> such as red, dry, itchy eyes we offer the right to file to the appropriate payor for such conditions. This will prompt our staff to file a claim according to the plan provisions for your Primary Medical Insurance.

Vision plans can then be used to file for your glasses or contacts. This will maximize your benefit and minimize your out of pocket cost. I have read and understood this information and I am signing voluntarily. Please note that contact lens benefits will be filed unless patient states otherwise. Please indicate whether you would like your benefits filed for your exam and contact lenses. YES NO ________ Initials

____
Patient/Guardian's Signature and Date