MEDICAL HISTORY

Name _____ M.I. _____ Date ____/____/____

Address _____ Phone _____

City _____ State _____ Zip _____ Cell Phone _____

Guardian (if applicable) _____ Email _____

Birthdate ____/____/____ Last Eye Exam ____/____/____ Occupation _____

Do you have vision insurance? ☐ No ☐ Yes If yes, insurance carrier _____

Do you have health insurance? ☐ No ☐ Yes If yes, insurance carrier _____

Do you have medicare? ☐ No ☐ Yes

☐ Male ☐ Female

Medical History

List medications you take (including oral contraceptives, aspirin, over-the-counter medications, and home remedies)

_____

_____

_____

Check any of the following that you have had: ☐ age-related macular degeneration ☐ inflammatory disorder ☐ cataract ☐ strabismus ☐ keratoconus ☐ amblyopia ☐ glaucoma suspect ☐ glaucoma ☐ surgery ☐ retinal degeneration/hole/detachment ☐ patching ☐ eye injury

Are you pregnant and/or nursing? ☐ No ☐ Yes

Do you wear glasses? ☐ No ☐ Yes If yes, how old is your present pair of lenses? _____

Do you wear contact lenses? ☐ No ☐ Yes If yes, what brand? _____

Type of contact lenses: ☐ Rigid ☐ Soft ☐ Extended Wear ☐ Other Are they comfortable? ☐ No ☐ Yes

Family History

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

Disease/Condition	Yes	No	?	Relationship
Thyroid Disease	☐	☐	☐	
Diabetes	☐	☐	☐	
Hypertension	☐	☐	☐	
Cancer	☐	☐	☐	
Strabismus	☐	☐	☐	
Cataract	☐	☐	☐	
Glaucoma Suspect	☐	☐	☐	
Amblyopia	☐	☐	☐	
Severe Myopia	☐	☐	☐	
Macular Degeneration	☐	☐	☐	
Retinal Detachment/Disease	☐	☐	☐	
Glaucoma	☐	☐	☐	
Severe Hyperopia	☐	☐	☐	
Other	☐	☐	☐	

Social History – This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

☐ Yes, I prefer to discuss my Social History information directly with the doctor.

Do you drive? ☐ No ☐ Yes If yes, do you have visual difficulty when driving? ☐ No ☐ Yes If yes, please describe:

_____

Do you use tobacco products? ☐ No ☐ Yes If yes, type/amount/how long _____

Are you a ☐ Former Smoker ☐ Current Occasional Smoker ☐ Current Everyday Smoker

Do you drink alcohol? ☐ No ☐ Yes If yes, type/amount/how long _____

Do you use illegal drugs? ☐ No ☐ Yes If yes, type/amount/how long _____

Name _____ Date ____/____/____

Review of Systems Do you currently, or have you ever had, any problems in the following areas:

	Yes	No
Eyes		
Itching	☐	☐
Diplopia	☐	☐
Burning	☐	☐
Mattering	☐	☐
Loss of Vision	☐	☐
Photophobia	☐	☐
Red	☐	☐
Floaters	☐	☐
Loss of Sharpness	☐	☐
Flashes	☐	☐
Tearing	☐	☐
Other_____		
Constitutional		
Developmental Disorders	☐	☐
Cancer	☐	☐
Fatigue Syndrome	☐	☐
Other_____		
Ear, Nose, Mouth, Throat		
Sinusitus	☐	☐
Dry Mouth	☐	☐
Hearing Loss	☐	☐
Laryngitis	☐	☐
Other_____		
Neurological		
Epilepsy	☐	☐
Multiple Seizures	☐	☐
Tumor	☐	☐
Cerebral Palsy	☐	☐
Stroke/CVA	☐	☐
Migraine	☐	☐
Other_____		
Psychiatric		
Depression	☐	☐
Bipolar	☐	☐
Anxiety	☐	☐
Attention Deficit	☐	☐
Other_____		
Vascular/Cardiovascular		
Vascular Disease	☐	☐
Stroke	☐	☐
Heart Disease	☐	☐
High Blood Pressure	☐	☐
Congestive Heart Failure	☐	☐
Other_____		
Respiratory		
Cigarette Smoker	☐	☐
Bronchitis	☐	☐
COPD	☐	☐
Emphysema	☐	☐
Asthma	☐	☐

	Yes	No
Respiratory (continued)		
Sleep Apnea	☐	☐
Other_____		
Gastrointestinal		
Celiac Disease	☐	☐
Crohn's Disease	☐	☐
Ulcer	☐	☐
Colitis	☐	☐
Acid Reflux	☐	☐
Other_____		
Genitourinary		
Kidney Disease	☐	☐
STD - Herpetic/Chlamydia	☐	☐
Prostate Disease/Cancer	☐	☐
Pregnant/Nursing	☐	☐
Other_____		
Musculoskeletal		
Arthritis	☐	☐
Ankylosing Spondylitis	☐	☐
Fibromyalgia	☐	☐
Muscular Dystrophy	☐	☐
Osteoarthritis	☐	☐
Gout	☐	☐
Other_____		
Integumentary		
Herpes Simplex/Cold Sores	☐	☐
Herpes Zoster/Shingles	☐	☐
Rosacea	☐	☐
Psoriasis	☐	☐
Eczema	☐	☐
Other_____		
Endocrine		
Diabetes Type II	☐	☐
Thyroid Dysfunction	☐	☐
Hormonal Dysfunction	☐	☐
Diabetes Type I	☐	☐
Other_____		
Hematologic/Lymphatic		
Large Volume Blood Loss	☐	☐
Anemia	☐	☐
Ulcer	☐	☐
High Cholesterol	☐	☐
Other_____		
Allergic/Immunologic		
Environmental Allergies	☐	☐
Lupus	☐	☐
Rheumatoid Arthritis	☐	☐
Drug Allergies	☐	☐
If yes, what drug?_____		
Sjogrens Syndrome	☐	☐
Other_____		

If you answered yes to any of the above, or have a condition not listed, please explain:

_____

_____

_____

Doctor's Signature_____ Date ____/____/____

Signature on File Form

• *RESPONSIBILITY STATEMENT* •

Your insurance is a method for you to receive reimbursement for fees you have paid to the optometrist for services rendered. Having insurance is not a substitute for payment. Many companies have fixed allowances or percentages based on your contract with them not with our office. It is your responsibility to pay in advance for the deductible, coinsurance, or any other balances not paid for by your insurance. We will assist you in receiving reimbursement as much as possible, but you are responsible in advance for your bill.

• *FINANCIAL RESPONSIBILITY* •

By signing this statement you agree to be financially responsible for all charges.

• *AUTHORIZATION TO RELEASE MEDICAL INFORMATION* •

I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine benefits or the benefits payable for related services. This assignment will remain in effect until revoked in writing. A photocopy of this assignment is considered to be as valid as the original.

Patient Signature_____ Date_____

Witness _____ Date_____

No Refund Policy

Due to the time involved and custom nature of eyewear: **all sales are final**.

If there is an optical problem we are better served to solve than anybody else, but we do not count buyer's remorse as an optical issue.

Eye glass orders are highly customized and cannot be canceled once they have been placed. A restocking fee may be assessed on stopped orders.

In the event of an Rx-change or change to the lenses either by the Doctor or by the patient, we adhere to a 30 day return policy for a redo at no additional cost from the date of pickup. After those 30 days, exchanges and Rx-changes will vary upon the type of lenses or lab used and may be subject to fees.

Verification of benefits is not a guarantee of payment or coverage and copay's are subject to change at the discretion of the insurance once a claim is received.

Please take the time to choose out a frame and any add-ons to lenses that you will be happy and comfortable with. We strive to be a family oriented business, to be honest and dependable and do not want our patients to feel like we are attempting to take advantage of them.

We will do our best to make sure that we are charging you correctly for the items you get through your insurance and are not liable for any additional charges that are stated by the insurance after they receive the claim.

We thank you for your business and your cooperation.

Please sign this form as an understanding of our No Refund Policy and that you have read all of the above.

Patient or Parent/Guardian Signature

Date _____

I, _____

ACKNOWLEDGE RECEIPT OF Dr. Lawrence Adegite's,

"Notice of Privacy practices"

Date_____

Signature_____

RELATION TO THE ABOVE_____

Primary Care Physicians

Dr. Adegite and his team care immensely about the health of your eyes and there are a number of diseases that can effect your eye vision such as Diabetes and Hypertension.

That means we also care about your overall physical health and to help in treating any unknown illnesses or health conditions we would like to make sure that you already have a primary care physician.

Please allow us to help in the treatment of your physical and eye health by filling out the items below.

Please circle your answers below.

Do you have a primary care physician?

Yes No

If you circled yes, what is your primary physician's name, address and telephone number?

_____

_____

If you circled no, do you need any assistance in finding a primary care physician?

Yes No

Thank you for your cooperation.

COVID-19 WAIVER AND RELEASE OF LIABILITY

In consideration of the risk of exposure while visiting at Rivers In The Desert Eye Clinic, and as consideration for the right to visit Rivers In The Desert Eye Clinic, I hereby, for myself, my heirs, executors, administrators, assigns or personal representatives, knowingly and voluntarily enter into this waiver and release of liability and hereby waive any and all rights, claims, or causes of action of any kind whatsoever arising out of my visit at Rivers In The Desert Eye Clinic, and do hereby release and forever discharge Dr. Lawrence Adegite and this establishment, located at 306 S. Lake St in Farmington, NM 87401, their affiliates, managers, members, agents, attorneys, staff, volunteers, representatives, predecessors, successors, and assigns, for any physical or psychological injury, including but not limited to illness, paralysis, death, damages, economical or emotional loss, that I may suffer as a direct result of my willingness to visit Rivers In The Desert Eye Clinic, including traveling to and from an event related to Rivers In The Desert Eye Clinic.

I AM VOLUNTARILY PARTICIPATING IN THE AFOREMENTIONED ACTIVITY AND I AM PARTICIPATING IN THE ACTIVITY ENTIRELY AT MY OWN RISK. I AM AWARE OF THE RISKS ASSOCIATED WITH TRAVELING TO AND FROM AS WELL AS PARTICIPATING IN THIS ACTIVITY, WHICH MAY INCLUDE BUT ARE NOT LIMITED TO, PHYSICAL OR PSYCHOLOGICAL INJURY, PAIN, SUFFERING, ILLNESS, TEMPORARY OR PERMANENT DISABILITY (INCLUDING PARALYSIS), ECONOMIC OR EMOTIONAL LOSS, AND DEATH. I UNDERSTAND THAT THESE INJURIES OR OUTCOMES MAY ARISE FROM MY OWN OR OTHERS' NEGLIGENCE, CONDITIONS RELATED TO TRAVEL, OR THE CONDITION OF THE ACTIVITY LOCATION(S). NONETHELESS, I ASSUME ALL RELATED RISKS, BOTH KNOWN OR UNKNOWN TO ME, OF MY PARTICIPATION IN THIS ACTIVITY, INCLUDING TRAVEL TO, FROM AND DURING THIS ACTIVITY.

I agree to indemnify and hold harmless Dr Lawrence Adegite and Rivers In The Desert Eye Clinic against any and all claims, suits, or actions of any kind whatsoever for liability, damages, compensation or otherwise brought by me or anyone on my behalf, including attorney's fees and any related costs, if litigation arises pursuant to any claims made by me or by anyone else acting on my behalf. If Dr. Lawrence Adegite and Rivers In The Desert Eye Clinic incurs any types of these expenses, I agree to reimburse Dr. Lawrence Adegite and Rivers In The Desert Eye Clinic.

I acknowledge that Dr. Lawrence Adegite and Rivers In the Desert Eye Clinic and their directors, officers, volunteers, representatives and agents are not responsible for errors, omissions, acts or failures to act of any party or entity conducting a specific event or activity on behalf of Rivers In The Desert Eye Clinic.

I ACKNOWLEDGE THAT I HAVE CAREFULLY READ THIS "WAIVER AND RELEASE" AND FULLY UNDERSTAND THAT IT IS A RELEASE OF LIABILITY. I EXPRESSLY AGREE TO RELEASE AND DISCHARGE DR. LAWRENCE ADEGITE AND RIVERS IN THE DESERT EYE CLINIC AND ALL OF ITS AFFILIATES, MANAGERS, MEMBERS, AGENTS, ATTORNEYS, STAFF, VOLUNTEERS, HEIRS, REPRESENTATIVES, PREDECESSORS, SUCCESSORS AND ASSIGNS, FROM ANY AND ALL CLAIMS OR CAUSES OF ACTION AND I AGREE TO VOLUNTARILY GIVE UP OR WAIVE ANY RIGHT THAT I OTHERWISE HAVE TO BRING A LEGAL ACTION AGAINST DR. LAWRENCE ADEGITE AND RIVERS IN THE DESERT EYE CLINIC FOR PERSONAL INJURY OR PROPERTY DAMAGE.

To the extent that statute or case law does not prohibit releases for negligence, this release is also for negligence on the part of Rivers In The Desert Eye Clinic, its agents and employees.

In the events that I should require medical care or treatment, I agree to be financially responsible for any costs incurred as a result of such treatment. I am aware and understand that I should carry my own health insurance.

In the event that any damage to equipment or facilities occurs as a result of my or my family's willful actions, neglect or recklessness, I acknowledge and agree to be held liable for any and all costs associated with any actions of neglect or recklessness.

Please print/sign and date here:

Circle one of the following:

Print: _____ date_____ Patient (OR)

Sign: _____ date_____ Parent/Guardian of Patient

_____ (patients name if under the age of 18.)