Roth Eye Care

Eye Desire Eyecare & Optical Boutique

Dr. David M. Roth Dr. Ashley Roth

Optometric Physicians

Our Mission

Our knowledgeable doctors and staff are fully committed to providing our patients with the highest quality eyecare and service. We look forward to taking care of your eyes in the years ahead.

WELCOME TO OUR OFFICE

(PLEASE PRINT)

Name _____ Date_____/_____/_____

Please circle (Dr., Mr., Mrs., Ms., Miss)

Spouse or Parent _____

Mailing Address _____

City, State, Zip _____

Date of Birth _____ Age _____ Sex: M F

Home Phone _____ Work Phone _____ Cell Phone _____

Social Security # _____ E-mail address _____

How did you first hear about our office?

☐Insurance ☐Community Event ☐Internet (Which site? i.e Google, Yelp) _____

☐Physician... Who?_____ ☐Friend/Relative... Who? _____

☐Other _____

Occupation (or Grade) _____

Employer (or School) _____

What is the main purpose for this visit? _____

Any problems with your present contact lenses or glasses? _____

Vision Insurance: ☐VSP ☐Eyemed ☐Humana/VCP ☐Other_____

Medical Insurance: _____

VISUAL NEEDS

Are you planning to get new glasses today? ☐Yes ☐No

Are you planning to get new contacts today? ☐Yes ☐No

Do You... (check those that apply)

☐Wear glasses?

☐Wear bifocals?

☐Wear progressives?

☐Wear contact lenses? What kind? _____

☐Want to try contact lenses?

☐Use eye drops? What kind? _____

☐Work at a computer? How many hours per day? _____Headaches? _____

☐Want information about vision correction without surgery (Orthokeratology/GMT)?

☐Want information about Lasik surgery?

☐Participate in sport activities? Which? _____

PLEASE COMPLETE INFORMATION ON NEXT PAGE

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Do you experience... (check those that apply)

☐Blurry Distance Vision	☐Headaches	☐Itchiness	☐Sudden Loss of Vision
☐Blurry Near Vision	☐Glare or Reflection	☐Dryness	☐Sensitivity to Light
☐Double Vision	☐Redness	☐Gritty Feeling	☐Fainting or Dizziness
☐Trouble Seeing at Night	☐Burning	☐Flashes of Light	☐Nausea
☐Eye Strain	☐Watery Eyes	☐Floaters	☐Other _____

SOCIAL HISTORY

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer. This information is important for medical purposes as well as compliance with insurance directives.

Do you use tobacco products? ☐Yes ☐No Are you HIV Positive? ☐Yes ☐No
Do you drink alcohol? ☐Yes ☐No

MEDICAL HISTORY

☐Allergies	☐Heart Disease	☐Macular Degeneration
☐Asthma	☐Cancer	☐Eye Injury
☐Diabetes	☐Arthritis	☐Eye Surgery. Type? _____ When? _____
☐High Blood Pressure	☐Kidney Problems	☐Cataracts
☐High Cholesterol	☐Nerve Disorder	☐Glaucoma
☐Thyroid	☐Skin Disorder	☐Other _____

Are you allergic to any medications?_____

CURRENT MEDICATIONS (RX or over the counter)

Medication Name

☐Antihistamines _____ Others: _____
☐Blood Pressure Pills _____ _____
☐Cholesterol Pills _____ _____
☐Diuretic (water pills) _____ _____
☐Oral Contraceptives _____ _____

Date of Last Eye Exam _____
Name of Last Eye Doctor _____
Date of Last Physical Exam _____
Name of Physician _____

FAMILY MEDICAL HISTORY

Relationship to you

☐Blindness _____
☐Cataracts _____
☐Macular Degeneration _____
☐Glaucoma _____
☐Diabetes _____
☐High Blood Pressure _____
☐Cancer _____
☐Other _____

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VISUAL FIELD EXAMINATION

Our OCULUS EASYFIELD VISUAL FIELD TESTER electronically measures peripheral and central vision and can assist us in the early detection of many disorders including brain tumors, glaucoma, macular degeneration, and retinal detachments.

We strongly recommend that all of our patients receive the screening version of this exam. It is especially important for people who have:

1) Glaucoma
2) Family history of Glaucoma
3) Headaches
4) See spots or flashes of light
5) A history of diabetes
6) A history of high blood pressure
7) Circulatory problems
8) A strong eyeglass prescription

There is an additional charge of $30.00 for the screening exam.

☐I DO want the visual field exam. ☐I DO NOT want the field exam.

DILATION CONSENT

In accordance with Florida law, this office offers dilation at no additional cost to your examination. Dilating your eyes gives the doctor an expanded view of the inside of your eyes, and is helpful in detecting cataracts, glaucoma, retinal detachments, and other ocular disorders.

NOTE: Due to the enlargement of the pupils, dilation may affect the comfort of some patients when reading or driving (usually 2 to 3 hours) and creates sensitivity to bright lights (usually 3 to 4 hours). This effect may be prolonged in those wearing contact lenses.

PLEASE CHECK A BOX BELOW AND SIGN.

☐I ACCEPT dilation ☐I would like to RESCHEDULE dilation

☐I DECLINE dilation

I understand the risks and benefits associated with pharmacologic dilation of the pupils and have made my decision via informed consent.

SIGNATURE_____DATE_____

CONTACT LENS FIT & FOLLOW UP POLICY

This section is for patients getting a Contact Lens Exam. If you do not wear contact lenses please disregard.

A Contact Lens Exam, also known as a contact lens fit and follow up, includes the following.

- Glasses prescription
- Contact lens prescription
- Trial contact lenses
- Contact lens insertion, removal, and maintenance training (If necessary).
- Up to 3 follow up visits within 90 days of original exam (If 90 days passes a follow up fee will be charged. If 6 months has passed a new exam is required and the full exam fee will be charged).

SIGNATURE_____DATE_____

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Dr. David M Roth
Optometric Physician
1211 17th Street Miami Beach, FL 33139
305.673.1211

Missed Appointment and Cancellation Policy

Dear Patient,

Your appointment is held **exclusively** for you. In the event that you need to cancel your appointment, you must do so 24 hours in advanced in order to permit us to fill your appointment with another patient.

Missed appointments or appointments not canceled 24 hours in advance are subject to a $25 missed/late cancellation fee.

Additionally, I understand I will be responsible for payment of all fees related to the collection of any unpaid balances, and that my Insurance Company is not responsible for any fees incurred for missed/late appointment cancellations.

We appreciate your understanding in this matter.

SIGNATURE_____DATE_____