

Welcome to our Office

Patient's Name: _____ Today's Date: _____
Birth Date: _____ Soc. Security No.: _____ Driver's License #: _____
Address: _____ Home Phone: _____
City: _____ Zip: _____ Cell Phone: _____
Your Employer: _____ Occupation: _____ Business Phone: _____
Address: _____ City/Zip: _____
Spouse/Dom.Partner/Parent's Name: _____ Pt. of this Office? _____
Children's Names and Ages (At Home): _____
Other Family Members that are Patients of this Office: _____
How did you find out about our Office? Referred by Relative / Friend Who: _____
Location _____ Advertisement _____ Insurance Listing _____ Phone Book _____ Web Site _____ Other _____

Insurance and Payment Information:

It is the policy of this office that payment is expected when services are rendered. When prescription eyewear or optical products are ordered, a minimum deposit of 1/2 down is required. Balance is due on delivery of the prescription materials unless other arrangements are made in advance.

Our office accepts many types of Vision Insurance and in most cases we will accept payment directly from your insurance carrier. Individuals will be responsible for all deductibles and charges not completely covered by their insurance. Our office will bill Vision Insurance Carriers for individuals. However, the patient is responsible for all charges incurred and any claims of non-payment by an Insurance Carrier are between the patient and Insurance Company.

Please circle your intended method of payment: Cash / Check Visa / MasterCard / Discover Card

I would like this Office to bill my insurance: VSP MES Superior MediCal Medicare Other _____

I have read the above and understand my responsibilities. Signed: _____

Visual History: (please fill in or circle the appropriate answer)

Date of Last Eye Exam: _____ Doctor: _____ City: _____

Do you wear Glasses: Yes / No Date of Last Prescription: _____ Doctor: _____

Do you wear Contacts: Yes / No Date of Last Prescription: _____ Doctor: _____

Type of Contact Lenses: Rigid Gas Perm. / Soft / Extended Wear / Other / Unknown

When do you wear your Glasses / Contacts: Fulltime / Distance Only / Near Only / Dist. & Near Detail / Rarely

Do you feel there has been a change in your vision since your last visual examination? Yes / No / ?

Are you interested in wearing Contact Lenses? Yes / No / ? If yes, Why? _____

Medical History:

Date of Last Medical Exam: _____ Doctor: _____ City: _____

Do you have any allergies to Medications? Yes / No If yes, which Medication(s): _____

List any medications you are currently taking (including oral contraceptives, aspirin, over the counter medications & home remedies): _____

List any major injuries, surgeries and / or hospitalizations you have had: _____

List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, glaucoma, retinal disease, cataracts, eye injuries, eye infections or eye surgery: _____

Are you pregnant and / or nursing? Yes / No If pregnant, when is your due date: _____

Please turn this form over and complete side two

Family History: Please note any family history (parents, grandparents, siblings, children; living or deceased)

Disease / Condition	Yes	No	?	Relationship	Disease / Condition	Yes	No	?	Relationship
Blindness	___	___	___	_____	Diabetes	___	___	___	_____
Cataracts	___	___	___	_____	Heart Disease	___	___	___	_____
Crossed Eyes	___	___	___	_____	High Blood Pressure	___	___	___	_____
Glaucoma	___	___	___	_____	Kidney Disease	___	___	___	_____
Macular Degen.	___	___	___	_____	Lupus	___	___	___	_____
Retinal Detach.	___	___	___	_____	Thyroid Disease	___	___	___	_____
Arthritis	___	___	___	_____	Cancer	___	___	___	_____
Other	___	___	___	_____					

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

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

Do you drive? Yes / No If yes, do you have visual difficulty when driving? Yes / No

If yes, please describe: _____

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

Do you drink Alcohol? Yes / No If yes, type / amount / how long: _____

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

Have you ever been exposed to or infected with: Gonorrhea / Hepatitis / HIV / Syphilis

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

System	Yes	No	?	System	Yes	No	?
Constitutional				Ears, Nose, Mouth, Throat			
Fever, Recent Weight Loss / Gain	___	___	___	Allergies / Hay Fever	___	___	___
Integumentary (Skin) Eczema	___	___	___	Sinus Congestion	___	___	___
Neurological				Runny Nose	___	___	___
Headaches	___	___	___	Post Nasal Drip	___	___	___
Migraines	___	___	___	Chronic Cough	___	___	___
Seizures	___	___	___	Dry Throat / Mouth	___	___	___
Visual System				Respiratory			
Loss of Vision	___	___	___	Asthma	___	___	___
Blurred Vision (Distance/Near/Both)	___	___	___	Chronic Bronchitis	___	___	___
Distorted Vision / Halos	___	___	___	Emphysema	___	___	___
Loss of Side Vision	___	___	___	Vascular / Cardiovascular			
Double Vision	___	___	___	Diabetes	___	___	___
Frequent Dryness	___	___	___	Heart Pain	___	___	___
Mucous Discharge	___	___	___	High Blood Pressure	___	___	___
Frequent Redness	___	___	___	Vascular Disease	___	___	___
Sandy or Gritty Feeling	___	___	___	Gastrointestinal			
Itching or Burning	___	___	___	Diarhea	___	___	___
Foreign Body Sensation	___	___	___	Constipation	___	___	___
Excess Tearing / Watering	___	___	___	Acid Reflux	___	___	___
Glare / Light Sensitivity	___	___	___	Genitourinary			
Eye Pain or Soreness	___	___	___	Genitals / Kidney / Bladder	___	___	___
Chronic Eye / Lid Infections	___	___	___	Bones / Joints / Muscles			
Frequent Sties or Chalazions	___	___	___	Rheumatoid Arthritis	___	___	___
Flashes / Floaters in Vision	___	___	___	Muscle Pain	___	___	___
Chronic Tired Eyes	___	___	___	Joint Pain	___	___	___
Endocrine				Neck / Back Pain	___	___	___
Thyroid / Other Glands	___	___	___	Psychiatric			
Allergic / Immunologic				Anxiety / Depression	___	___	___

If you answered YES to any of the above or have a condition not listed, please explain and list Medications:

Thank you for completing this form. The information you have provided will be helpful to the Doctor in determining your visual requirements.