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:

When prescription eyewear or optical products are ordered, full payment is required, unless other arrangements are made in advance. Since prescription eyewear is not re-useable, it is not returnable and no refunds can be made on prescription products.

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. Insurance coverage is not a guaranteed payment and the patient is responsible for all charges incurred. 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 / Am. Express

I would like this Office to bill my insurance: VSP MES Superior EyeMed 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 difficultly 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 recreational 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	___	___	___	Diarrhea	___	___	___
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..