

WELCOME TO OUR OFFICE

Date: _____
Last: _____ First: _____
Street: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____
Work Number: _____ Cell Number: _____
Emergency Contact & Number: _____
Patient Date of Birth: _____ Age: _____ Sex: M F
Employer/School: _____
Occupation/Grade: _____
Spouse/Parent's Name: _____
Spouse/Parent's Work: _____
E-mail address (for office newsletter and eye health updates): _____
Any problems with your present contact lenses or glasses? Please explain: _____

INSURANCE INFORMATION

Vision Insurance: _____
Subscriber Name: _____
Subscriber ID Number: _____
IF VSP Last Four Digits of Subscriber SS#: _____
IF Davis Vision/Eyemed Subscriber SS#: _____
Subscriber Date of Birth: _____
Medical Insurance: _____
Subscriber Name: _____
Subscriber ID Number: _____
Subscriber Date of Birth: _____
Secondary Medical Insurance: _____
Subscriber Name: _____
Subscriber ID Number: _____
Subscriber Date of Birth: _____

FAMILY MEDICAL/EYE HISTORY (Check all that apply)

	Relationship
<input type="checkbox"/> Blindness	_____
<input type="checkbox"/> Cataracts	_____
<input type="checkbox"/> Corneal Problems	_____
<input type="checkbox"/> Glaucoma	_____
<input type="checkbox"/> Macular Degeneration	_____
<input type="checkbox"/> Retinal Problems	_____
<input type="checkbox"/> Lazy Eye	_____
<input type="checkbox"/> Diabetes	_____
<input type="checkbox"/> High Blood Pressure	_____
<input type="checkbox"/> Heart Disease	_____
<input type="checkbox"/> Other Eye/Health Problems	_____

PATIENT MEDICAL HISTORY

Name of Family Physician: _____
City: _____ State: _____ Zip Code: _____
Date of Last Physical Check -Up: _____

CURRENT MEDICATIONS (Rx or Over the Counter)

(List name of medications including eye drops, vitamins & birth control pills)
Allergies to Medications: YES NO
List: _____
Have you ever been diagnosed or treated for the following?
 Allergies Diabetes Nerves
 Asthma Heart Disease Thyroid
 Arthritis High Blood Pressure Other: _____
 Cancer Kidney _____
 Cholesterol Lyme Disease

PATIENT EYE HISTORY

Date OF Last Eye Exam: _____
By Whom? _____
Do you currently wear contact lenses? YES NO
What kind? _____
If not, are you interested in contacts? YES NO
Do you...
...Have more than 1 pair of glasses? YES NO
...Work at a computer for long periods? YES NO
...Want info on Laser Vision Correction? YES NO
...Have family in need of eye care now? YES NO
Have you ever been diagnosed or treated for the following?
 Cataracts Glaucoma Eye Injury
 Corneal Abrasion Iritis/Uveitis Lazy Eye
 Macular Degeneration Retinal Detachment
 Eye Infection Other Eye Disorders: _____
Do you experience or have ever experienced...
 Blurry Vision Flashes of Light Redness
 Floaters/Black Spots Light Sensitivity Tearing
 Reading Problems Crossed Eye/Eye Turn Eye Pain
 Headaches Double Vision Burning
 Eye Strain Trouble Seeing at Night Itchiness
 Dryness or Glare Grittiness

VERY IMPORTANT

Who may we thank for referring you to our office?
Name of friend or relative: _____
If not referred, how did you chose our office for your visual needs?
 Relative Friend Doctor Drove By Insurance
 Yellow Pages Other: _____
Doctor's Signature: _____

PUPIL DILATION

As part of our comprehensive eye examination, we instill eye drops in order to fully assess the health of the inside of your eyes.

YES

NO

We recommend a Visual Field Screening and/or Retinal Photographs be taken as part of your yearly eye exam.

It allows us to provide you with the most comprehensive care.

VISUAL FIELD SCREENING

A Visual Field Screening is a computerized test to detect the presence of any defects or "blind spots" in your vision. The fee for this test is \$40.

YES

NO

Retinal Photography

Retinal Photographs are Polaroid pictures of the retina or back of your eyes. The fee for this test is \$40.

YES

NO

Please remember it is your responsibility to ensure all referrals and certification procedures are followed. Some procedures may require a referral from your primary care physician, in which you must bring the referral form, and your current insurance card on the day services are rendered and materials are ordered. If you notify us after services are rendered, we will supply you with a coded receipt for you to submit for reimbursement directly from your insurance plan. If you have vision coverage with a plan our office does not participate with we will supply you with a coded receipt.

Assignment & Release:

I hereby authorize the physician to release any medical information as needed.
I hereby authorize my insurance benefits to be paid directly to the physician, and understand I am financially responsible for non-covered services. Insurance coverage is not a guarantee of payment. In the event of an insurance denial, I understand that I will be responsible for payment.

Acknowledgement of Privacy and Contact Lens Policies:

I have read and understand these practices' Notices of Privacy and Contact Lens Policies on the attached sheet. It provided in detail the uses and disclosures on my protected health information and individual rights. I understand I can obtain a copy of the Privacy Practices upon request. By signing, I understand the office's policies and fees.

X _____ Date: _____