

Today's Date _____

Last Name _____ First Name _____ MI _____ DOB _____ Age _____
Address _____ City _____ State _____ ZIP _____
Male _____ Female _____ Home Phone (____) _____ Business Phone (____) _____
Occupation _____ Vision/Optical Insurance _____
Name of the Insured _____ Employer of the insured _____
Soc. Sec. # of insured _____ - _____ - _____ ID # of insured _____
DOB of insured _____ Referred by _____

Primary reason for visit: _____
Last exam date: _____ Age of present glasses: _____ Age of present contacts: _____

Do you have previous history of:

eye disease/eye trauma? y / n
vision therapy/patching? y / n
frequent headaches? y / n
flashes of light/floaters? y / n
double vision? y / n
eye discomfort/burning/itching? y / n

Do blood relatives have a history of:

glaucoma? y / n
retinal detachment? y / n
strabismus? y / n
other eye disease? y / n
diabetes? y / n
high blood pressure? y / n

Medical History: do you have any of the following?

high blood pressure? y / n
arthritis/collagen vascular disease? y / n
heart disease? y / n
cancer? y / n
other medical conditions? y / n Please list: _____
diabetes? y / n
thyroid disease? y / n
gastrointestinal problems? y / n
asthma or lung disease? y / n

Medications: Please list: _____

Allergies (drug or environmental) _____

Is this exam for contacts? Y / N If yes, have you worn contacts before? Y / N

I UNDERSTAND THERE IS AN ADDITIONAL FEE FOR CONTACT LENS FITTING AND SERVICES. _____

Type of contacts: _____ toric _____ gas perm/hard _____ disposable _____ monovision _____ reusable _____ unknown

Email Address to order contacts online _____

Are you interested in laser vision correction? Y / N

DILATION of the pupils: For some patients, dilation of the pupils is necessary to get an optimal view of the inside of the eye and may be recommended by the eye doctor. Use of this procedure can help the doctor rule out eye diseases such as glaucoma, macular degeneration, cataracts, retinal degeneration, diabetes and high blood pressure. Afterwards, you may experience mildly blurred vision when reading and increased light sensitivity for 2 to 3 hours. We provide disposable sunglasses for increased comfort during this time.

() I DO give permission to be dilated. () I do NOT give permission to be dilated.
() I DO want this service but would like to reschedule for another day.

I UNDERSTAND THAT SHOULD MY INSURANCE NOT COVER THE TOTAL COSTS OF THIS VISIT I WILL BE FINANCIALLY RESPONSIBLE FOR THESE FEES BEFORE LEAVING THE OFFICE TODAY.

Signature _____ Date _____