Welcome to Visual Eyes – *Your Lifetime Eyecare Center*

Today's Date: ____________ Date of Last Eye Exam: ____________

Contact Information

Name: _________________________

Street: _________________________

City_______________ State ________

Zip code: ______________________

Home Phone:

____

Work Phone:

____

Cell Phone:

____

Personal Information

Employer:

____

SS Number: _______- ______- _________

DOB: ______________ Age ____________

Sex: ______Male ______Female

Spouse/Parent Name:

____

Spouse /Parent Cell Phone:

____

Personal & Family Medical History

Circle all that apply:

Allergies	Yes	No
Asthma	Yes	No
Arthritis	Yes	No
Cancer	Yes	No
Diabetes	Yes	No
Glaucoma	Yes	No
Eye Diseases	Yes	No
Heart Disease	Yes	No
Eye Injury	Yes	No
High Blood Pressure	Yes	No

Current Medications
(Rx & Over –the-Counter)

Antihistamines	Yes	No	____________________
Diuretics (Water Pill)	Yes	No	____________________
Blood Pressure Pills	Yes	No	_____________________
Oral Contraceptives	Yes	No	_____________________
Sleeping Pills	Yes	No	_____________________
Eye Drops	Yes	No	_____________________

Vitamins or Other Supplements _____________________

Are you currently under the care of a physician? Yes No
Name of physician: _____________________________________

How did you hear about us?

- ☐ Friend or relative
- ☐ Another healthcare Practitioner
- ☐ Yellow Pages
- ☐ Newspaper Advertisement
- ☐ Direct Mailer
- ☐ Another patient
- ☐ Participating eye care plan

Please provide us with a name of any of the referral sources checked above so we may thank them properly:

____

____

____

Diagnostic Issues/ Lifestyle Questions

Please list any complaints or problems you have wearing glasses or contacts:

Do you have more than one (1) pair of current prescription glasses? **No** **Yes**

Do you work on a computer for long periods of time? **No** **Yes**

If you wear glasses, would you benefit from thinner, lighter lenses? **No** **Yes**

Do you spend a lot of time outdoors? **No** **Yes**

If you wear bifocals, are you bothered by restricted windows, lines or head tilting? **No** **Yes**

If you wear contact lenses, are you satisfied with the vision and comfort? **No** **Yes**

Are you interested in a “trial” of the latest in contact lens design? **No** **Yes**

Do you desire information regarding laser vision correction and/or a free evaluation regarding your candidacy? **No** **Yes**

Do You Experience…

- Any discomfort with your eyes? **No** **Yes**
- Problems with glare or reflection? **No** **Yes**
- Sensitivity to light? **No** **Yes**
- Headaches? **No** **Yes**
- Floaters or flashes of light? **No** **Yes**

Dilation…

To dilate your eyes, the doctor will use drops to cause your pupils to enlarge. With the pupils dilated, the doctor has a better opportunity to examine the inside of your eyes. If you are a new patient to the practice or you have a family history of eye health or general health problems, the doctor will suggest having your pupils dilated today. The drops are fast acting and usually take effect in 20-30 minutes. The total effect on vision lasts 3-5 hours with near vision being affected most. It will be safe to drive home after having your pupils dilated.

______**I wish** ____**I do not** wish to be dilated today. _____ **(initial)**

Assignment of Insurance Benefits

I request that payment of my insurance benefits, including Medicare, be made payable to **Visual Eyes** for any services rendered to me by that doctor or supplier. I authorize the medical information about me may be released to my insurance company and its agents any information needed to determine these benefits or the benefits payable for related services. I also accept financial responsibility for medical claims billed to my insurance company and not paid within 30 days.

I understand I am financially responsible for all services, deductibles, and other charges not covered by my insurance carrier.

______________________________ ______________________________

Patient Signature **Date**

Thank you….

The information you have provided will help us serve your health care needs more effectively. If you have any questions at any time please ask; we are always happy to help.

______________________________ ______________________________

Patient Signature **Date**

Patient Privacy Notice-Acknowledgement of Receipt

At your initial visit a copy of the **Visual Eyes** privacy practices will be presented to you. After you have read our privacy notice please sign and date below to acknowledge you received the information.

______________________________ ______________________________

Patient Signature **Date**