

WELCOME

PLEASE PRINT

CIRCLE ONE: Mr. Mrs. Ms. Miss Dr.

Today's Date: ____/____/____

First _____ Last _____ Middle Initial _____

Address: _____ City _____ State _____ Zip _____

Home Phone: (____) _____ Business Phone:(____) _____

E-Mail Address: _____ Cell Phone: _____ (Optional)

Date of Birth: _____ Age: _____ Social Security No. _____

Occupation: _____ Employer: _____

Do you have vision insurance? VSP _____ Davis Eyemed Other _____

Name of policy holder _____ His/Her D.O.B _____

Relation to Patient _____ Insured's Social Security # _____

How Were You Referred To Our Office? **Insurance: Web Page: Phone Book: Friend / Family: Other** _____

What Is The Reason For Your Visit Today? _____

How Long Since Your Last Eye Exam? _____ Were Your Eyes Dilated For That Exam? Y / N / Don't Know

Do You Wear Eyeglasses? YES / NO Are you planning to get glasses today? YES / NO / NOT SURE

Do You Wear Contact Lenses? YES / NO Are you planning to get contacts today? YES / NO / NOT SURE

Type of Contacts you wear: Soft Gas Permeable Disposable Daily Overnight Occasional Use

Do You Currently, Or Have You Ever Had Any Problems In The Following Areas? If YES, Please Explain:

Retinal Detachment _____ Glaucoma _____

Cataracts _____ Macular Degeneration _____

Crossed Eyes _____ Dry Eyes _____

Lazy Eye _____ Retinal Disease _____

Other Vision / Eye Medical Problems: _____

MEDICAL HISTORY

Do You Have Diabetes? _____ High Blood Pressure? _____ Pregnant / Nursing? _____

Do You Currently, Or Have You Ever Had Any Problems In The Following Areas? If YES, Please Explain:

Gastrointestinal _____ Musculoskeletal _____

Nervous _____ Endocrine _____

Cardiovascular _____ Integumentary (Skin) _____

Ears, Nose, Throat _____ Allergic / Immunologic _____

Respiratory _____ Genitourinary _____

PLEASE LIST YOUR CURRENT MEDICATONS: _____

Allergies To Medications?: _____

Other Allergies: _____

Major Injuries or Surgeries You Have Had: _____

PLEASE CONTINUE ON THE OTHER SIDE

FAMILY HISTORY

Please Note Any **Family History** For The Following Conditons:

High Blood Pressure	Y / N	Relation_____	Macular Degeneration	Y / N	Relation_____
Heart Disease	Y / N	Relation_____	Blindness	Y / N	Relation_____
Diabetes	Y / N	Relation_____	Retinal Detachment	Y / N	Relation_____
Glaucoma	Y / N	Relation_____	Cataracts	Y / N	Relation_____
Crossed Eyes	Y / N	Relation_____	Thyroid Disease	Y / N	Relation_____
Cancer	Y / N	Relation_____	Arthritis	Y / N	Relation_____
Other Diseases or Conditions?		Relation_____			Relation_____

SOCIAL HISTORY

This Information is Kept Confidential. If You Prefer You Can Discuss This Portion Directly With The Doctor

Do You Use Tobacco?	Y / N	Have You Been Infected or Exposed To:	HIV, Hepatitis, STD's,
Do You Use Alcohol?	Y / N	Do You Use Illegal Drugs?	Y / N
Do You Drive?	Y / N		

Doctor's Signature _____ *Date* _____

PUPIL DILATION RELEASE

We may be using drops to dilate (enlarge) the pupils of your eyes to observe the retina and other structures of the eye. This procedure that can help in the early detection of eye disease and some systemic disorders. Side effects may include light sensitivity and blurry vision. The effects should wear off in several hours.

If you do not want your eyes dilated at this visit please acknowledge by signing the release below.

Before Deciding You Can Discuss This With The Doctor

I have been made aware of the benefits of this procedure in the early detection of disease.

I DO NOT wish to have my eyes dilated at this time

Patient Signature: _____ **Date:** _____

RELEASE AUTHORIZATIONS:

- I understand that:
1. Professional fees are due at the time of service.
 2. A minimum deposit of 30% is required before glasses or contact lenses will be ordered.
 3. I am ultimately responsible for all fees and material charges.

I affirm that all information above is complete and accurate to the best of my knowledge.

Patient Signature (or responsible adult): _____ **Date:** _____