# WELCOME TO OUR OFFICE

## Patient Information

**Today's Date** ____________________

Last ____________________

First ____________________MI ___

Street ____________________

City ______________ State ______________

Zip Code ____________________

Home Phone ____________________

Cell Phone ____________________

Work Phone ____________________

E-mail ____________________

Sex ❑M ❑F Birth Date __________Age ______

❑Single ❑Married ❑Widowed ❑Minor

Occupation (or Grade) ____________________

Employer (or School) ____________________

Spouse (or Parent's) Name ____________________

Spouse (or Parent's) Work ____________________

Whom may we thank for recommending you or how did you hear of us?

____________________

What is the major purpose of this visit?

____________________

____________________

____________________

List Hobbies/Interests (helps us determine your visual needs)?

____________________

____________________

## Insurance Information

Who is responsible for this account?____________________
Relationship to Patient____________________

Vision Insurance ____________________
Subscriber Name____________________
Subscriber SSN____________________
Subscriber Birth Date____________________

Primary Medical Insurance____________________
Subscriber Name____________________
Subscriber SSN____________________
Subscriber Birth Date____________________
Do you participate in a flex spending account?
❑ Yes ❑ No

### Notice of Payment Policy

All professional fees, including exam and any additional testing recommended by the doctor, are due and payable the day they are provided. If glasses are included in your fees, 50% is required when ordering and the balance is due at dispensing.

If your fees are covered by a vision or medical plan for which we participate, any applicable deductibles, co-payments, and non-covered services and/or materials are due and payable on the date of your examination.

A cash payment agreement is available to patients whose examination fees are not covered by a vision plan or who do not have any type of vision coverage. By signing a cash payment agreement the patient agrees to the terms of the contract which provide a reduction in our usual and customary examination fee. This agreed upon amount, as determined by the contract, is payable at the time of your initial visit.

*I understand that any fees incurred are my responsibility, unless otherwise prohibited by law, regardless of any insurance benefits, and said fees are to be paid as stated in the above payment policy. Any collections and/or legal fees are my responsibility.*

Payment will be made by: (Please check one)

❑Self(Ask for Financial Agreement/Contract)
❑Insurance as listed above

____________________

Patient/Parent or Guardian Signature Date

**The information in this confidential case history form is critical to the evaluation of your vision and health.**

## Patient Medical History

Name of Family Physician____________________________
Date of Last Physical Check-up________________________

**CURRENT MEDICATIONS (Rx or Over the Counter)**
(List name of medications including eye drops, vitamins, & birth control pills)___________________________________
_____________________________________________________
_____________________________________________________

Do you have any allergies to medications? ❑Yes ❑ No

If yes, what medications?_______________________________
_____________________________________________________

Do you smoke? ❑ Yes ❑ No Packs/day____________
Do you use alcohol? ❑ Yes❑ No Drinks/day_________

Are you pregnant? ❑ Yes ❑ No

Have you had any surgeries? ❑ Yes ❑ No
If yes, please list______________________________________
_____________________________________________________
_____________________________________________________

**Have you ever been diagnosed or treated for the following health problems? Check only if yes and specify.**

| | Yes | |
|---|---|---|
| Allergies | ❑ | ____________ |
| Arthritis | ❑ | ____________ |
| Asthma | ❑ | ____________ |
| Blood/Lymph | ❑ | ____________ |
| Cancer | ❑ | ____________ |
| Cardiovascular | ❑ | ____________ |
| Cholesterol | ❑ | ____________ |
| Diabetes | ❑ | ____________ |
| Digestive | ❑ | ____________ |
| Ears/Nose/Throat (Sinus) | ❑ | ____________ |
| Eczema/Rashes | ❑ | ____________ |
| Genitourinary | ❑ | ____________ |
| High Blood Pressure | ❑ | ____________ |
| Integumentary (Skin) | ❑ | ____________ |
| Kidney | ❑ | ____________ |
| Muscle/Bone | ❑ | ____________ |
| Neurological | ❑ | ____________ |
| Migraines | ❑ | ____________ |
| Psychological (Anxiety) | ❑ | ____________ |
| Respiratory (COPD) | ❑ | ____________ |
| Thyroid | ❑ | ____________ |

ENVISION
EYE CARE

## Patient Eye History

Date of Last Eye Exam____________________________
By Whom?_______________________________________

Do you wear glasses? ❑ Yes ❑ No
If yes,
❑All the time For: ❑Distance ❑Near ❑Both
or
❑Occasionally For: ❑Distance ❑Near ❑Both

Do you have problems with glare or reflections?
❑ Yes ❑ No

Are you interested in contact lenses? ❑ Yes ❑ No

Have you ever tried contact lenses? ❑ Yes ❑ No

Do you currently wear contact lenses? ❑ Yes ❑ No
What kind?______________________________________
Solutions used____________________________________

Are you satisfied with the vision and comfort of your contact lenses? ❑ Yes ❑ No

**Have you ever experienced, been diagnosed or treated for any of the following? Check only if yes.**

| | |
|---|---|
| ❑ Blurry Vision | ❑ Burning |
| ❑ Cataracts | ❑ Corneal Abrasions |
| ❑ Crossed eye/Eye turn | ❑ Double Vision |
| ❑ Eye Infections | ❑ Eye Injury |
| ❑ Flash of light | ❑ Floaters/Spots |
| ❑ Glaucoma | ❑ Grittiness |
| ❑ Headaches | ❑ Iritis/Uveitis |
| ❑ Itchiness | ❑ Lazy Eye |
| ❑ Macular Degeneration | ❑ Occasional dryness |
| ❑ Retinal Detachment | ❑ Sunlight Sensitivity |
| ❑ Excessive Tearing | ❑ Trouble seeing at night |
| ❑ Uncomfortable glasses | |
| ❑ Other eye disorders____________________ | |

## Family Medical/Eye History (Check all that apply)

Is there a family medical history of any of the following? Please indicate relationship (Mother's or Father's side).

| | |
|---|---|
| Blindness | ❑____________________ |
| Cataracts | ❑____________________ |
| Corneal Problems | ❑____________________ |
| Diabetes | ❑____________________ |
| Glaucoma | ❑____________________ |
| Heart Disease | ❑____________________ |
| Lazy Eye | ❑____________________ |
| Macular Degeneration | ❑____________________ |
| Retinal Problems | ❑____________________ |