Vision Source

INSIGHT EYECARE

For a Lifetime of Healthy Eyesight

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Welcome to Our Office

Today's Date _____ (Please Print)

Name _____

Street _____

City _____ State _____ Zip _____

Home Phone _____

Work Phone _____

Employer (or School) _____

Occupation (or Grade) _____

Social Security Number _____

Spouse (or Parent's Name) _____

Date of Birth _____ Age _____ Sex: Male Female

Email Address _____

What is the purpose of this visit?

_____

Any problems with your present contact lenses or glasses?

_____

VERY IMPORTANT! NEW PATIENTS ONLY:

Who may we thank for referring you to our office?

Name of friend or relative _____

If not referred, how did you choose our office for your needs?

☐ Another Dr. ☐ Insurance List
☐ Saw Sign/Building ☐ Newspaper/Radio/TV
☐ Yellow Pages: Which directory? _____
☐ Web Page: Which Web Site _____
☐ Other _____

INSURANCE INFORMATION

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
☐ Cash ☐ Check ☐ Credit Card

Family Medical/Eye History (check all that apply)

Is there a family history of any of the following?

	Relationship		Relationship
Blindness	☐ _____	Cataracts	☐ _____
Corneal Transplant	☐ _____	Lazy Eye	☐ _____
Glaucoma	☐ _____	Retinal Problems	☐ _____
Macular Degeneration	☐ _____	Cataracts	☐ _____
Heart Disease	☐ _____	Diabetes	☐ _____

Please be aware that most eye health plans do not cover contact lens services and these will be billed separately.

Please be aware that your vision insurance is a contract between you and your insurance company and not us. We will help you fill out insurance forms and submit them for you. However, if your insurance company ahs not paid us in 90 days, we will put the balance on your credit card.

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 _____

Town _____

Date of Last Physical Check-up _____

CURRENT MEDICATIONS (R_x or Over the Counter)

(List name of medications including eye drops, vitamins, & birth control pills) _____

_____

_____

Allergies to Medications: ☐ Yes ☐ No What kind? _____
Do you smoke? ☐ Yes ☐ No
Do you drink? ☐ Yes ☐ No How many per week? _____
Do you use illegal drugs? ☐ Yes ☐ No What kind? _____

Have you ever been diagnosed or treated for the following?

☐ Allergies ☐ Diabetes ☐ Thyroid
☐ Asthma ☐ Heart Disease ☐ Other
☐ Arthritis ☐ High Blood Pressure _____
☐ Cancer ☐ Kidney _____
☐ Cholesterol ☐ Nerves

PATIENT EYE HISTORY

Date of Last Eye Exam _____

By Whom? _____

Do you currently wear contact lenses? ☐ Yes ☐ No

What kind? _____

Solutions used? _____

Would you prefer clear contact lenses or colored contact lenses to change the color of your eyes? _____

Have you ever tried contact lenses? ☐ Yes ☐ No

Do you... (Check box if your answer is yes)

☐ Work at a computer? If so, how many hours a day? _____
☐ Think you might benefit from thinner, lighter lenses?
☐ Have interest in a "Test Drive" of the latest contact lens designs?
☐ Spend time outdoors? (How much? _____hrs/week)
☐ Have prescription sunglasses?
☐ Prefer not to wear your glasses at times?
☐ Want information on Laser Vision Correction surgery?
☐ Have interest in a non-surgical approach to vision correction?
☐ Have more than 1 pair of prescription glasses?
☐ Have children?
☐ Have family members in need of eyecare?

If you wear bifocals, do the lines or head tilting bother you?
☐ Yes ☐ No

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

Have you ever been diagnosed or treated for the following?

☐ Cataracts ☐ Iritis/Uveitis
☐ Corneal Abrasion ☐ Lazy Eye
☐ Eye Infection ☐ Macular Degeneration
☐ Eye Injury ☐ Retinal Detachment
☐ Glaucoma ☐ Other Eye Disorders

Do you experience or have you ever experienced?

☐ Blurry Vision ☐ Flash of Light ☐ Sunlight Sensitivity
☐ Burning ☐ Floaters/Spots ☐ Crossed Eye/Eye Turn
☐ Tearing ☐ Grittiness ☐ Trouble Seeing at Night
☐ Headaches ☐ Itchiness ☐ Uncomfortable Glasses
☐ Double Vision ☐ Occasional Dryness