Eye Designs VISION

Welcome to our office!

Today's Date ______________ ❒ Mr. ❒ Mrs. ❒ Ms.

Last Name ______________________________

First Name ______________________________

Middle Initial _____ Date of Birth _______________

SSN ______________________ Gender M F

Address ______________________________

City _________________ Zip Code __________

Home Phone ____________________________

Cell Phone ____________________________

Employer ______________________________

Occupation ______________________________

Email Address ___________________________

Insurance Information (If being utilized)

Insurance name______________________________

Primary insured's name_______________________

Primary insured's date of birth_______________

Relationship to insured_______________________

ID #_______________________________________

How did you hear about us?

❏ Google ❏ Facebook ❏ Yelp ❏ Driveby

❏ DemandForce ❏ Website

❏ Referred by ___________________________

What are some of your hobbies or tasks that you may need glasses for?

____

Eye Health Information

Date of last eye exam ______________________

Are you interested in ❏ Glasses ❏ Contacts ❏ LASIK

Do you currently wear prescription glasses? Yes No

Have you previously worn contact lenses? Yes No

Rate how your contact lenses feel immediately after you first put them in.

	1	2	3	4	5	6	7	8	9	10	
POOR	☼	☼	☼	☼	☼	☼	☼	☼	☼	☼	EXCELLENT

Rate how your contact lenses feel just before you take them out.

	1	2	3	4	5	6	7	8	9	10	
POOR	☼	☼	☼	☼	☼	☼	☼	☼	☼	☼	EXCELLENT

Do you use contact lens rewetting drops? Yes No

Have you experienced:

	Present	Past
Blurred Vision	☼	☼
Blurred Vision with Correction	☼	☼
Double Vision	☼	☼
Red/Irritated Eyes	☼	☼
Dry Eyes	☼	☼
Itchy Eyes	☼	☼
Eye Fatigue	☼	☼
Headaches	☼	☼
Difficulty Reading	☼	☼
Eye Injury	☼	☼
Floaters/Flashes of light	☼	☼
Light Sensitivity	☼	☼

Do you use a computer frequently? Yes No

How many hours? _____________

Are there any other concerns you would like to discuss with the Doctor?

____

Please turn over.

General Medical Information

Last Physical Date______________________________

Doctor's Name______________________________

Current Medications______________________________

____

Medication Allergies______________________________

Surgeries______________________________

Is there a possibility you are pregnant? Yes No

Have you been diagnosed with any of the following?
If so, Please Explain:

☼Ears/Nose/Throat______________________________

☼Neurological______________________________

☼Psychiatric______________________________

☼Cardiovascular(Heart)______________________________

☼Respiratory______________________________

☼Gastrointestinal______________________________

☼Genitourinary______________________________

☼Muscles/Bones______________________________

☼ Integumentary (Skin Conditions)______________________________

☼ Endocrine (Thyroid/Diabetes)______________________________

☼Allergic/Immunologic______________________________

☼ Other Health Issues______________________________

Have you or anyone else in the family been diagnosed with the following?

	Self	Family	Relation
High Blood Pressure	☼	☼	____________
Diabetes (Type 1 or 2)	☼	☼	____________
Cancer	☼	☼	____________
Glaucoma	☼	☼	____________
Macular Degeneration	☼	☼	____________
Retinal Detachment	☼	☼	____________
Cataracts	☼	☼	____________
Other (please specify)	☼	☼	____________

Dilation Information

It is our goal to provide a complete and thorough comprehensive eye examination. To effectively accomplish our goal, we feel it is important to dilate the pupils of your eyes. This will require placing drops in your eyes. As with many medications, there are some side effects of the drops used to dilate the pupil. These include; sensitivity to light and blurred vision up close. In most cases, the distance vision is not affected. The side effects usually last several hours but can, in some cases, last up to 24 hours. While we believe that dilation is an important part of the eye examination process, we understand that you may wish to defer or decline this procedure. Please indicate your preference below:

❑ **I wish to be dilated today.**

❑ **I do not wish to be dilated at this time, but will return for this procedure at a later date. (No additional charge within 90 days from your examination date.).**

❑ **I do not wish to be dilated and agree to hold Valerie Potter, O.D. / Victoria Melcher, O.D., harmless as a result of my actions.**

HIPPA Compliance Acknowledgement of Receipt

I acknowledge that I have received a copy of Valerie Potter, O.D./Victoria Melcher, O.D. Notice of Privacy Practices. Please allow access to all of my patient records and information to:

Patient, Parent, or Guardian Signature:

______________________________**Date**__________

Financial Information

Payment for services is required at the time of service. To our patients with medical and/or vision benefits: We will be happy to file your insurance claims or take assignment on your medical/vision benefits. Plan(s) of which you state you are a member, we will do all we can to help you receive maximum benefits. However, in the event that the plan sponsor determines that you are not eligible for coverage at the time of service, or makes a determination that you are eligible for a reduced level of coverage, by signing this statement you hereby agree to be financially responsible for any and all charges incurred by you and not paid by the plan sponsor.

Patient, Parent, or Guardian Signature:

______________________________**Date**__________