WELCOME TO OUR OFFICE

Patient Information

Last ____
First _______________________MI ________________
Nickname _______________________________________
Sex M F Date of Birth ______/______/______
Street ____
Apt # _______________City ________________ State __
Zip Code_____________
Occupation (or Grade) ____________________________
Employer (or School) _____________________________
Name of Account Responsible
____
Relationship to Acct. Responsible__________________

What is the major purpose of this visit?
____
____
____

Any problems with your current contact lenses or glasses?
____
____
____

Are you interested in Laser Vision Correction surgery?
Y / N

Contact Information

Preferred method of contact (check all the applies):

- ❑ Home ❑ Cell ❑ Work
- ❑ Email ❑ Text ❑ US Mail

Home Phone _____________________________________
Work Phone _____________________________________
Cell Phone ______________________________________
Email____

Emergency Contact _______________________________

Referral Information

Who may we thank for referring you to our office?
Name of friend or relative _________________________

If not referred, how did you find us?

- ❑ Another Doctor
- ❑ Insurance List
- ❑ Saw Sign/Building
- ❑ Facebook/Yelp/Webpage ______________________
- ❑ Other ______________________________________

facebook.com/AdvancedVisionCareOpt

Insurance Information

Please note that insurance does NOT cover the Contact Lens Fitting Evaluation.

Vision Insurance__________________________________
Subscriber Name__________________________________
Subscriber SSN____________________________
Subscriber Birth Date______________________________

Primary Medical Insurance__________________________
Subscriber Name__________________________________
Subscriber SSN___________________________________
Subscriber Birth Date______________________________

Lifestyle Questions

Do you…

- ❑..work at a computer? If yes, how many hours? _______
  Distance from monitor in inches __________________
- ❑..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 sun wear?
- ❑..prefer not to wear your glasses at times?
- ❑..have interest in a non-surgical approach to vision correction?
- ❑..have more than 1 pair of current Rx eyewear?
- ❑..have family members in need of eyecare?

Have you ever experienced, been diagnosed or treated for any of the following?

❑ 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
❑ Tearing	❑ Trouble seeing at night
❑ Uncomfortable glasses	❑ Droopy eyelids

❑ Other eye disorders______________________________
____
____
____
____
____

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 (Rx or Over the Counter)
(List name of medications including eye drops, vitamins, & birth control pills)____________________________________

Allergies to medications? ❑ Yes ❑ No
If so, what medications?______________________________

Have you had any surgeries? ❑ Yes ❑ No
Do you use cigarettes/tobacco, alcohol, or other substances? ❑ Yes ❑ No If yes, please circle.

Have you ever been diagnosed or treated for the following health problems?

	Yes	**No**
Allergies	❑	❑
Arthritis	❑	❑
Blood/Lymph	❑	❑
Bronchitis	❑	❑
Cancer	❑	❑
Cholesterol	❑	❑
Diabetes	❑	❑
Digestive	❑	❑
Ears/Nose/Throat	❑	❑
Endocrine	❑	❑
Eczema/Rashes	❑	❑
Fatigue	❑	❑
Fevers	❑	❑
Genitourinary	❑	❑
High Blood Pressure	❑	❑
Integumentary (Skin)	❑	❑
Kidney	❑	❑
Muscle/Bone	❑	❑
Neurological	❑	❑
Psychological	❑	❑
Respiratory	❑	❑
Sinus	❑	❑
Throat Infections	❑	❑
Thyroid	❑	❑
Unusual weight losses/gains	❑	❑

If you checked yes to any of the above please explain ___

Patient Eye History

Date of Last Eye Exam______________________________
By Whom?____

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

Would you prefer clear contact lenses or colored contact lenses? ❑ Clear ❑ Colored

Family Medical/Eye History (Check all that apply)

Is there a family medical history of any of the following:
❑ No ❑ Yes (Please check boxes)

	Relationship
Blindness	❑________________________
Cataracts	❑________________________
Corneal Problems	❑________________________
Diabetes	❑________________________
Glaucoma	❑________________________
Heart Disease	❑________________________
Lazy Eye	❑________________________
Macular Degeneration	❑________________________
Retinal Problems	❑________________________

Please be advised if you are using insurance coverage for today's visit, this is a contract between you and your insurance company...not Advanced Vision Care.

Signature____