

Today's Date _____

Patient Information

Last _____
 First _____ MI _____
 Street _____
 City _____ State _____
 Zip Code _____
 Home Phone _____
 Cell Phone _____ Text __ Yes __ No
 Date of Birth _____ Age _____
 Sex M F
 Patient's SSN _____
 Employer (or School) _____
 Occupation (or Grade) _____
 Spouse (or Parent's Name) _____
 Spouse (or Parent's Work) _____
 Email Address _____

What is the major purpose of this visit?

Are you planning on getting new glasses today?
 __ Yes __ No

Any problems with your current 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?

- Google / Yahoo search
- Insurance List
- Saw Sign
- Facebook
- Yellow Pages book
- Yelp
- Website

At Vision Source of Howell, it is our mission to offer you the best eye care available. We do this by providing state-of-the-art care and outstanding customer service in a fun and friendly atmosphere. Our team of doctors and staff always recommend the most advanced products that are tailored to your individual needs and improve the quality of your vision. Finally, we guarantee that we will meet and exceed your expectations.

Insurance Information

Please note that insurance does NOT cover the Contact Lens Follow-Up Evaluation.

Vision Insurance _____
 Subscriber Name _____
 Subscriber SSN/ID _____
 Subscriber Birth Date _____

Primary Medical Insurance _____
 Subscriber Name _____
 Subscriber SSN/ID _____
 Subscriber Birth Date _____

Do you participate in a flex spending account?

- Yes No

How will you settle your account today?

- Cash Check Credit Card

Lifestyle Questions

Do you(r).....(check box if your answer is yes)

- ..eyes bother you while reading? while on computer?
- ..eyes, when you read, the print ever blur, double, move?
- ..think you might benefit from thinner, lighter lenses?
- ..have interest in a "test drive" of the latest contact lens designs?
- ..spend time outdoors? _____Hrs/week
- ..have prescription sunwear?
- ..prefer not to wear your glasses at times?
- ..want information on Laser Vision Correction surgery?
- ..have more than 1 pair of current Rx eyewear?
- ..have children? Ages _____
- ..have family members in need of eyecare?

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

- | | |
|--|--|
| <input type="checkbox"/> Blurry Vision | <input type="checkbox"/> Burning |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Corneal Abrasions |
| <input type="checkbox"/> Crossed eye/Eye turn | <input type="checkbox"/> Double Vision |
| <input type="checkbox"/> Eye Infections | <input type="checkbox"/> Eye Injury |
| <input type="checkbox"/> Flash of light | <input type="checkbox"/> Floaters/Spots |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Grittiness |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Iritis/Uveitis |
| <input type="checkbox"/> Itchiness | <input type="checkbox"/> Lazy Eye |
| <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Occasional dryness |
| <input type="checkbox"/> Retinal Detachment | <input type="checkbox"/> Sunlight Sensitivity |
| <input type="checkbox"/> Tearing | <input type="checkbox"/> Trouble seeing at night |
| <input type="checkbox"/> Uncomfortable glasses | |
| <input type="checkbox"/> Other eye disorders _____ | |

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? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If so, what medications? _____		

Have you had any surgeries? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Do you use cigarettes/tobacco, alcohol, or other substances? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Have you ever been diagnosed or treated for the following health problems?		
	Yes	No
Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Blood/Lymph	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Digestive	<input type="checkbox"/>	<input type="checkbox"/>
Ears/Nose/Throat	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine	<input type="checkbox"/>	<input type="checkbox"/>
Eczema/Rashes	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Fevers	<input type="checkbox"/>	<input type="checkbox"/>
Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Integumentary (Skin)	<input type="checkbox"/>	<input type="checkbox"/>
Kidney	<input type="checkbox"/>	<input type="checkbox"/>
Muscle/Bone	<input type="checkbox"/>	<input type="checkbox"/>
Neurological	<input type="checkbox"/>	<input type="checkbox"/>
Psychological	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>
Sinus	<input type="checkbox"/>	<input type="checkbox"/>
Throat Infections	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Unusual weight losses/gains	<input type="checkbox"/>	<input type="checkbox"/>

Patient Eye History	
Date of Last Eye Exam _____	
By Whom? _____	
Have you ever tried contact lenses?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you currently wear contact lenses?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Interested in daily disposable contacts?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Experience end of day dryness?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you satisfied with the vision and comfort of your contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Would you prefer clear contact lenses or colored contact lenses? <input type="checkbox"/> Clear <input type="checkbox"/> Colored	
If you wear bifocals, do the lines or head tilting bother you? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Family Medical/Eye History (Check all that apply)	
Is there a family medical history of any of the following: <input type="checkbox"/> No <input type="checkbox"/> Yes (Please check boxes)	
	Relationship (Mother's or Father's side)
Blindness	<input type="checkbox"/> _____
Cataracts	<input type="checkbox"/> _____
Corneal Problems	<input type="checkbox"/> _____
Diabetes	<input type="checkbox"/> _____
Glaucoma	<input type="checkbox"/> _____
Heart Disease	<input type="checkbox"/> _____
Lazy Eye	<input type="checkbox"/> _____
Macular Degeneration	<input type="checkbox"/> _____
Retinal Problems	<input type="checkbox"/> _____

ASSIGNMENT AND RELEASE	
I, the undersigned, assign directly to this office all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am responsible for all copays and deductibles due on the day of service. If you are unable to make a payment on the day of service, we would like to inform you that it is our policy to add a \$10 surcharge for any billing statements sent to collect on copays. This is to recuperate costs associated with processing, sending, and filing these statements. I understand that I am financially responsible for all charges not paid by insurance after 90 days. I hereby authorize the doctor to release all information to secure the payment of benefits. I authorize the use of this signature on all insurance submission.	
Signature _____	_____
Responsible Party Signature	Date

