WELCOME TO OUR OFFICE

Patient Information

Full Name:_____
Birth Date:_____ Gender: M F

Address:_____
City:_____State_____Zip:_____
Cell Phone:_____
Work/Day Phone:_____
Email:_____
Patient SSN:_____
Marital Status:_____
Employer:_____
Occupation:_____
Do you have major medical insurance: ☐Yes ☐No
If yes, who is your carrier?_____
Does your plan include vision coverage: ☐Yes ☐No
If yes, who?_____

How would you prefer to be contacted?
Text Cell Phone Email
Other:_____

How did you hear about our office?

If you are new to our office, please share with us how you found us.
☐Another Patient:Who?_____
☐Insurance List / Insurance Website
☐Internet: Which website?_____
☐Kids Directory
☐Radio
☐YP (Yellow Pages)
☐Other:_____

Privacy Practices for Health Information

NOTICE OF PRIVACY PRACTICES: I/We have been offered a copy of Pierce Vision Specialists' statement on privacy practices.

AUTHORIZATION TO RELEASE INFORMATION: I/We hereby authorize Pierce Vision Specialists to release any medical or incidental information that may be necessary for medical benefit or to obtain payment for services. This includes but is not limited to vision plans or medical insurances.

CONSENT FOR TREATMENT: I/We hereby authorize Pierce Vision Specialists to administer diagnostic and medical procedures as may be necessary for proper health care.

FINANCIAL POLICY: I/We understand that charges incurred are ultimately the patient's responsibility. Past due accounts may be turned over to an outside collection agency.

_____ _____
Patient Signature Date

Lifestyle Questions

Are you planning on purchasing glasses today?
☐Yes ☐No ☐Maybe

Are you interested in getting a contact lens evaluation today? (Additional fees apply)
☐Yes ☐No ☐Maybe

Do you…? (Check all that apply)
☐…have ultraviolet protection sunwear?
☐…have "back up" prescription eyewear?
☐…wear contact lenses?
If so, what kind?_____
Solution used:_____
☐…experience discomfort with your contacts?
☐…work at a computer? _____ hours/day
☐…use a smart phone and/or tablet?
☐…play golf?
What are your hobbies?_____
_____
_____

What specific problems do you have with your vision, eyes, glasses, or contact lenses that you would like to discuss with the doctor today?_____
_____
_____
_____

OPTOMAP

We can now offer state-of-the-art technology to view the inside of your eye – *The optomap!* The optomap ultra-wide digital retinal imaging system helps you and your doctor make informed decisions about your eye health and overall well-being, without the need for dilation (If a retinal condition is found, dilation MAY be necessary).

The optomap enhances your doctor's ability to detect the earliest signs of eye disease such as; macular degeneration, glaucoma, retinal detachments, diabetic retinopathy, etc. There is an additional fee of only $35 for this procedure (covers both eyes).

☐Yes, I consent to having this doctor recommended procedure as part of my comprehensive exam.

☐No, I wish to decline the doctor's recommendation, and I agree to hold the practice harmless as a result.

_____
Patient Signature

Please turn over. Thank you.

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

Patient Eye History

Date of Last Eye Exam:_____
Previous Eye Doctor:_____

Have you ever experienced, been diagnosed, or been treated for any of the following? (Check all that apply)

	Currently	In the Past
Blurry Vision	☐	☐
Vision Loss	☐	☐
Corneal Abrasions	☐	☐
Double Vision	☐	☐
Eye turn/Crossed Eye	☐	☐
Floaters/Spots	☐	☐
Flash of light	☐	☐
Foreign Body	☐	☐
Headaches	☐	☐
Pain/Irritation	☐	☐
Red Eye	☐	☐
Eye Injury/Trauma	☐	☐
Eye Fatigue/Tired Eyes	☐	☐
Sensitivity to light	☐	☐
Dry Eye	☐	☐
Itchy/Burning Eyes	☐	☐
Watery Eyes	☐	☐
Motion Sickness	☐	☐
Losing Place when Reading	☐	☐

Other eye problems:_____

_____

_____

_____

_____

Family Medical / Eye History

Have you or a family member been diagnosed with any of the following? (Please check all that apply)

	Self	Which family member?
Blindness	☐	☐
Cataracts	☐	☐
Eye Turn	☐	☐
Glaucoma	☐	☐
Macular Degeneration	☐	☐
Retinal Problems	☐	☐
Diabetes	☐	☐
Heart Disease	☐	☐
Multiple Sclerosis	☐	☐
Eye Disease	☐	☐
Brain Tumor	☐	☐
Thyroid Condition	☐	☐

Patient Medical History

Primary Physician:_____
Date of Last Physical Exam:_____
Preferred Pharmacy:_____
CURRENT MEDICATIONS (List all medications including eye drops and supplements):_____

_____

_____

_____

_____

_____

_____

Are you allergic to medications? ☐Yes ☐ No
If so, what medications?_____

_____

Have you had any surgeries? ☐Yes ☐No
If so, please describe:_____

_____

_____

_____

Do you use: ☐Tobacco ☐Alcohol ☐Other substances

Have you ever been diagnosed or treated for the following health problems? (Check all that apply)

☐Allergies	☐Blood/Lymph
☐High Blood Pressure	☐Immune System
☐Cholesterol	☐STD
☐Cardiovascular	☐Skin/Eczema/Rashes
☐Anemia	☐Arthritis
☐Headaches/Migraines	☐Muscle/Bone
☐Diabetes	☐Neurological
☐Endocrine	☐Psychiatric
☐Digestive	☐Asthma
☐Kidney	☐Respiratory
☐Reproductive	☐Cancer

Other Health Problems:_____

_____

_____

_____

Did you know that some medical conditions and medications could affect your vision?

Your health history is important in evaluating your current and future eye health.