

WELCOME BACK TO OUR OFFICE

Patient Information

Today's Date _____ 20____

Last _____
First _____ MI _____
Street _____
City _____ State _____
Zip Code _____
Home Phone _____
Work/Alt Phone _____
Patient's SSN _____
Date of Birth _____ Age _____
Sex M F Marital Status S M D W
Employer (or School) _____
Occupation (or Grade) _____
Spouse (or Parent's Name) _____
Spouse (or Parent's Work) _____
Email Address _____

What is the major purpose of today's visit?

Any problems with your current contact lenses or glasses?

Our Mission

We are committed to developing and nurturing a life-long personal relationship with you and your family based on honesty, integrity, and professionalism.

We are dedicated to enhancing your quality of life through comprehensive eye health and vision assessments and educating you on the latest in high quality vision correcting products

We are devoted to providing this care in an atmosphere of friendliness, respect, and compassion and strive to exceed your expectations of superior customer service and great value.

Payment/Insurance Information

Who is responsible for this account? _____
Relationship to patient _____
How will you settle your account today?
 Cash Check Credit Card

If you have vision insurance or benefits please complete:

Plan Name _____
Subscriber Name _____
Subscriber SSN _____
Subscriber Birth Date _____
Employer _____

Do you participate in a flex spending account?
 Yes No

Authorization

I authorize the release of any medical or other information necessary to process this claim. I also authorize and assign the payment of vision benefits to Gering Vision Center, P.C.

_____ Date _____
(Primary policyholder or authorized persons signature)

Lifestyle Questions

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

- ..currently wear glasses
- ..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 sunwear?
- ..prefer not to wear your glasses at times?
- ..want information on Laser Vision Correction surgery?
- ..work at a computer? How much per day? _____ hours
- ..have more than 1 pair of current Rx eyewear?
- ..have family members in need of eyecare?
- ..have sensitivity to light/sun
- ..have trouble seeing at night
- ..have problems with ..reflections ..glare
- ..participate in sports? What? _____
- ..have hobbies? What? _____
- ..have special interests? What? _____

What do you like most about your current eyewear?

What do you like least?

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? <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? (check all that apply)	
<input type="checkbox"/> Allergies	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Blood/Lymph	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/> Cancer	<input type="checkbox"/> Cholesterol
<input type="checkbox"/> Diabetes Type _____	<input type="checkbox"/> Digestive
<input type="checkbox"/> Ears/Nose/Throat	<input type="checkbox"/> Endocrine
<input type="checkbox"/> Eczema/Rashes	<input type="checkbox"/> Fatigue
<input type="checkbox"/> Fevers	<input type="checkbox"/> Genitourinary
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Integumentary (Skin)
<input type="checkbox"/> Kidney	<input type="checkbox"/> Muscle/Bone
<input type="checkbox"/> Neurological	<input type="checkbox"/> Psychological
<input type="checkbox"/> Respiratory	<input type="checkbox"/> Sinus
<input type="checkbox"/> Throat Infections	<input type="checkbox"/> Thyroid
<input type="checkbox"/> Unusual weight losses/gains	<input type="checkbox"/> Migraine Headaches

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	
What brand/type? _____	
Solutions used _____	
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	
Have you had any eye operations? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Type _____	
Have you had any eye injuries? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Describe _____	
Have you ever experienced, been diagnosed, or treated for any of the following (please check all that apply):	
<input type="checkbox"/> Blurry Vision	<input type="checkbox"/> Cataracts
<input type="checkbox"/> Crossed Eyes	<input type="checkbox"/> Eye <input type="checkbox"/> Infection
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Floaters
<input type="checkbox"/> Macular Degeneration	<input type="checkbox"/> Dry Eyes
<input type="checkbox"/> Retinal Detachment	<input type="checkbox"/> Lazy Eye
<input type="checkbox"/> Excessive Tearing (watering)	<input type="checkbox"/> Iritis/Uveitis
<input type="checkbox"/> Double Vision	<input type="checkbox"/> Corneal Abrasions
<input type="checkbox"/> Flashes of Light	<input type="checkbox"/> "Burning" Eyes
<input type="checkbox"/> Itchy eyes	<input type="checkbox"/> "Gritty" Eyes
Do you experience chronic headaches? <input type="checkbox"/> Yes <input type="checkbox"/> No	
How frequent? _____	
What time of day? _____	
Where are they located? _____	

Family Medical/Eye History (Check all that apply)			
Is there a family medical history of any of the following:			
	Relationship (Mother's or Father's side)		Relationship (Mother's or Father's Side)
Blindness	<input type="checkbox"/> _____	Heart Disease	<input type="checkbox"/> _____
Cataracts	<input type="checkbox"/> _____	Diabetes	<input type="checkbox"/> _____
Corneal Problems	<input type="checkbox"/> _____	High Blood Pressure	<input type="checkbox"/> _____
Glaucoma	<input type="checkbox"/> _____		
Lazy Eye	<input type="checkbox"/> _____		
Macular Degeneration	<input type="checkbox"/> _____		
Retinal Problems	<input type="checkbox"/> _____		