WELCOME 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?
____
____

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?

- ❑ Another Doctor/Health Professional
- ❑ Insurance Provider List
- ❑ Saw Sign/Building
- ❑ Newspaper
- ❑ Yellow Pages: Which directory? ______________
- ❑ Web Page: Which Web Site? ________________
- ❑ Other ___________________________________

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? ❑ Yes ❑ No
If so, what medications?_____________________________
____

Have you had any surgeries? ❑ Yes ❑ No
Do you use cigarettes/tobacco, alcohol, or other substances? ❑ Yes ❑ No

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

- ❑ Allergies
- ❑ Blood/Lymph
- ❑ Cancer
- ❑ Diabetes Type____
- ❑ Ears/Nose/Throat
- ❑ Eczema/Rashes
- ❑ Fevers
- ❑ High Blood Pressure
- ❑ Kidney
- ❑ Neurological
- ❑ Respiratory
- ❑ Throat Infections
- ❑ Unusual weight losses/gains
- ❑ Arthritis
- ❑ HIV/AIDS
- ❑ Cholesterol
- ❑ Digestive
- ❑ Endocrine
- ❑ Fatigue
- ❑ Genitourinary
- ❑ Integamentory (Skin)
- ❑ Muscle/Bone
- ❑ Psychological
- ❑ Sinus
- ❑ Thyroid
- ❑ Migraine Headaches

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 brand/type?___________________________________
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

Have you had any eye operations? ❑ Yes❑ No
Type____
Have you had any eye injuries? ❑ Yes❑ No
Describe____
Have you ever experienced, been diagnosed, or treated for any of the following (please check all that apply):

- ❑Blurry Vision
- ❑Crossed Eyes
- ❑Glaucoma
- ❑Macular Degeneration
- ❑Retinal Detachment
- ❑Excessive Tearing (watering)
- ❑Double Vision
- ❑Flashes of Light
- ❑Itchy eyes
- ❑Cataracts
- ❑Eye ❑Infection
- ❑Floaters
- ❑Dry Eyes
- ❑Lazy Eye
- ❑Iritis/Uveitis
- ❑Corneal Abrasions
- ❑ "Burning" Eyes
- ❑ "Gritty" Eyes

Do you experience chronic headaches? ❑ Yes ❑ 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)
Blindness	❑__________________________
Cataracts	❑__________________________
Corneal Problems	❑__________________________
Glaucoma	❑__________________________
Lazy Eye	❑__________________________
Macular Degeneration	❑__________________________
Retinal Problems	❑__________________________

	Relationship (Mother's or Father's Side)
Heart Disease	❑__________________________
Diabetes	❑__________________________
High Blood Pressure	❑__________________________