

WELCOME TO OUR OFFICE

Today's Date _____

Patient Information

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

What is the major purpose of this 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 Dr.
- Insurance List
- Saw Sign/Building
- Newspaper/Radio/TV
- Yellow Pages: Which directory? _____
- Web Page: Which Web Site? _____
- Other _____

OUR MISSION STATEMENT

We are committed to providing comprehensive eye care of the highest quality to every patient that we have the privilege of helping. We will provide excellent service and eye care products to our patients to ensure their satisfaction. Our goal is to educate and inform our patients of their eye health status and vision care needs to help maximize their quality of life.

Insurance Information

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

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

Primary Medical Insurance _____
Subscriber Name _____
Subscriber SSN _____
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.....(check box if your answer is yes)

- ..work at a computer?
- ..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?
- ..have interest in a non-surgical approach to vision correction?
- ..have more than 1 pair of current Rx eyewear?
- ..have children?
- ..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 _____ | |

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? 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? 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

If you wear bifocals, do the lines or head tilting bother you? Yes No

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
(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"/> _____ |

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

We are happy to file a claim to your insurance company on your behalf. However, please be advised that this is not a guarantee of payment. You/Guardian are responsible for any balances left unpaid.

All payments and co-payments are due at time of service.

Signature _____