Dr.'s Signature ____________________________ Date ___________

Patient Welcome Form

Last Name ____________________________ First Name ____________________________ MI _____ Mr. Mrs. Ms. Dr.
Address ____ City ______________________ State _______ Zip _________
Home Phone (_____) ________________ Day Phone (______) ________________ Occupation _________________________________
Male / Female Date of Birth _____/_____/_____ Employer ____
Whom may we contact in case of emergency? _______________________ Phone # _______________ Relation ________________
Date of Last Eye Exam _______________ Name of Doctor ____________________ Hobbies ___________________________
Whom may we thank for referring you? (*Friend, Yellow Pages, Etc.*) ____
Do your wear glasses? **Y / N** If yes, how old is your current pair of glasses? ____
Do you wear contact lenses? **Y / N** How old is your current pair? ___________ Average hours of wear? ___________________
What type of lens do you wear? ☐Gas Permeable ☐ Daily Soft ☐ Disposables ☐ Toric ☐ _________________
What type of solution do you use? **Boston** **Renu** **Optifree** **Ultracare** **Complete** **Other**_________________
Are you interested in contact lenses? **Y / N** Please circle what type: Disposable Colored Gas Permeable Undecided
Have you had any surgical procedures on you eyes? **Y / N** What type? _________________________ Date of Surgery _________
Have you had any injury to your eyes? **Y / N** Please describe _________________________________ Date of Injury ___________
Do you or any of your family members have any of the following eye problems? (*Please check all that apply)*

	Yes	**No**	**Family**	**Relation**	**Description**
♦Cataracts	☐	☐	☐	_______________	____
♦Glaucoma	☐	☐	☐	_______________	____
♦Macular Degeneration	☐	☐	☐	_______________	____
♦Retinal Detachment/Disease	☐	☐	☐	_______________	____
♦Blindness, Color Blindness	☐	☐	☐	_______________	____
♦Lazy Eye	☐	☐	☐	_______________	____
♦Blurred / Distorted Vision	☐	☐	☐	_______________	____
♦Halos / Flashes / Floaters	☐	☐	☐	_______________	____
♦Redness or Pain	☐	☐	☐	_______________	____
♦Drooping Lids	☐	☐	☐	_______________	____
♦Glare / Light Sensitivity	☐	☐	☐	_______________	____
♦Excess Tearing / Discharge	☐	☐	☐	_______________	____
♦Visual Training	☐	☐	☐	_______________	____
♦Reading Problems	☐	☐	☐	_______________	____
♦Gritty/ Itching/ Burning	☐	☐	☐	_______________	____
♦Crossed eyes/ Eye turn	☐	☐	☐	_______________	____
♦Loss of side vision	☐	☐	☐	_______________	____
♦Sudden loss of vision	☐	☐	☐	_______________	____
♦Tired / Dry Eyes	☐	☐	☐	_______________	____
♦Chronic Eye or Lid Infection	☐	☐	☐	_______________	____

Please answer all that apply:
Diabetes **Y / N** Type ____ Date of Diagnosis ______________________
Headaches **Y / N** Allergies **Y / N** To what? __________________________ What happens? ___________________
Other Health Problems ____

Optomap or Dilation Consent: Retinal evaluation is an important part of the examination process that allows the doctor to view the periphery of the eye. By viewing the periphery the doctor can perform a thorough inspection for the presence of tumors, retinal detachments and other conditions that may cause floaters or flashes to appear suddenly in the vision. Dilation is included, Optomap has an extra fee, either is a recommended part of your comprehensive exam.
NOTE: Dilation will affect the comfort of many patients, the drops sting upon insertion, the near vision will be blurry for two hours and the drops will create light sensitivity for about four hours and effects but may last until morning. If this would cause an inconvenience, the dilation may be declined. Optomap is an instant procedure with no comfort effects.

Please initial on the line next to your response for each question:
Do you decline dilation and accept Optomap? _____Yes _____ No Would you like dilation? _____Yes _____ No
Some individuals cannot be dilated and some individuals may need dilation in addition to Optomap.

GENERAL HEALTH HISTORY: (*Please check all that apply*)

Please describe your general health for today: ____

	Yes	No	Family	Relation	Description
♦Ears/ Nose/ Throat	☐	☐	☐		
(Nasal Congestion, Chronic Cough, Hearing Difficulties)				____________	______________________________
♦Allergic / Immunologic	☐	☐	☐		
(Lupus)				____________	______________________________
♦Bones / Joints / Muscles	☐	☐	☐		
(Rheumatoid Arthritis, Joint Pain, Muscle Pain)				____________	______________________________
♦Cardiovascular	☐	☐	☐		
(High Blood Pressure, Heart Pain)				____________	______________________________
♦Blood / Lymph	☐	☐	☐		
(Anemia, Bleeding Problems)				____________	______________________________
♦Nervous	☐	☐	☐		
(Headaches, Seizures, Fainting)				____________	______________________________
♦Integumentary (Skin)	☐	☐	☐		
(Rosacea, Psoriasis)				____________	______________________________
♦Gastrointestinal	☐	☐	☐		
(Digestive Disorders)				____________	______________________________
♦Endocrine (Glands)	☐	☐	☐		
(Thyroid Disease)				____________	______________________________
♦Genitourinary	☐	☐	☐		
(Genitals, Kidneys, Bladder)				____________	______________________________
♦Respiratory	☐	☐	☐		
(Asthma, Emphysema, Chronic Bronchitis)				____________	______________________________
♦Constitutional	☐	☐	☐		
(Fever, Weight Loss/ Gain)				____________	______________________________
♦Cancer	☐	☐	☐	____________	______________________________
♦Psychiatric	☐	☐	☐	____________	______________________________

Please list any major injuries, surgeries, and/or hospitalizations: ____

____

Medication Allergies **Y / N** To what? ______________________ What happens? ______________

Current Medications ____

Have you discontinued any medications since your last visit? **Y / N** (*Please list medication and date that you discontinued usage*)

____

Have you had any operations? **Y / N** Type ____________________________ Date of Surgery __________

Name of your medical doctor __________________ Date of Last Visit ____________ Dr's Phone # ____________

Are you pregnant and/or nursing? **Y / N** Date of last tetanus shot ______________

Do you use any of the following: (*If yes, please indicate how often you use these products within an average week*)

Alcohol **Y / N** __________ Tobacco Products **Y / N** __________ Other Substances **Y / N** __________

Do you have an Advance Directive for healthcare? ____

An Advanced Health Care Directive is a plan for your future health care, should you be incapacitated or unable to convey your wishes. Having a Do-Not- Resuscitate order or a family member who has legal control over your health care, are examples of Advanced Health Care Directives.

Method of payment (Visa, MasterCard, Discover, Debit Card, Check or Cash)

Professional fees are due at the time services are rendered a $5.00 billing charge will be applied without exception to any outstanding balance and will accrue monthly. There is a $25.00 fee for returned checks. Medical insurance is a contractual arrangement between you and your insurance company. Patients are responsible for all costs not covered by insurance and any associated collection and legal fees. Patients with non-contractual insurance will be expected to pay in full at the time of service.

Person responsible for payment ______________________________ Relation ____________________

I have read the above and understand the office policies. I understand that any question I have left unanswered will be considered a refusal to answer: ____

Signature Date

Our Mission: "To provide a full range of quality eyecare services to fit your individual needs and lifestyle, ensuring your best vision today and your future eye health."