



WELCOME TO OUR OFFICE

Today's Date _____

Patient Information

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

What is the major purpose of this visit?

Are there 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

Mission Statement

The doctors and staff of Advanced Family Vision Optometry are fully committed to you and your family's total eye health and vision wellness. Our patients' eye care needs are our highest priority. We are Committed to providing state-of-the-art eye care and the finest eyewear products available in an atmosphere of uncompromised service, value, and friendliness.

Our practice is committed to staying in the forefront of eye care technology with the latest instrumentation and continuing education

Insurance Information

Please note that most insurance do NOT cover the Contact Lens Evaluation.

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

Primary Medical Insurance _____
 Subscriber Name _____
 Subscriber SSN _____
 Subscriber Birth Date _____

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 prescription 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 |

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,	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Alcohol	<input type="checkbox"/> Yes	<input type="checkbox"/> No
narcotics or other substances?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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"/>
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"/>
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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you currently wear contact lenses?	<input type="checkbox"/> Yes <input type="checkbox"/> No
What kind? _____	
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
If you wear bifocals, do the lines or head tilting bother you?	
	<input type="checkbox"/> Yes <input type="checkbox"/> No
Family Medical/Eye History (Check all that apply)	
Is there a family medical history of any of the following:	
<input type="checkbox"/> No	<input type="checkbox"/> 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 Advanced Family Vision Optometry.	
If your insurance company has not reimbursed our office in full within 60 (or 90) days, you will be responsible for the remainder of the balance. Thank you for your consideration.	
No Refunds are given for Professional Services.	
Signature: _____	
Date: _____	