PATIENT STATUS: ☐ NEW ☐ EXISTING

APPOINTMENT TIME: ______:______ A.M. P.M. APPOINTMENT DATE: ____________

PATIENT'S NAME: (TITLE, LAST, FIRST, M.I.)

Address:

City: State: Zip:

Date Of Birth: Sex ☐M ☐F

Home Phone: ( ) Work Phone: ( )

If you would like an email to alert you to upcoming promotions and/or to remind you of your next eye examination, please provide us your

E-mail Address: ____________

Primary Care Physician: ____________

Address: ____________

Phone: ( ) ____________

INSURED'S/GUARANTOR NAME: (LAST, FIRST, M.I.) Complete Insured Information Below

Address:

City: State: Zip:

Date Of Birth: / / Home Phone: ( ) Work Phone: ( )

Insured's Employer:

Primary Insurance:

Subscriber I.D.# ☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Patient's Relationship To Insured ☐Self ☐Spouse ☐Child ☐Other______

Secondary Insurance:

Subscriber I.D.# ☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Patient's Relationship To Insured ☐Self ☐Spouse ☐Child ☐Other______

Section 1 - Medical And Eyewear Information

1. Date Of Last Eye Examination: ____________
2. What Is The Reason For Your Examination Today? ____________
3. Have You Ever Had? ☐An Eye Injury ☐Eye Surgery ☐Vision Training ☐Spots ☐Floaters ☐Flashes ☐Double Vision ☐Head Injury ☐Lazy Eye
4. Have You Or Any Family Members Had? ☐Cataracts ☐Cancer ☐Diabetes ☐Glaucoma ☐High Blood Pressure ☐Macular Degeneration ☐Other______
   If yes, Which Family Member? ____________
5. Are You Taking Any Type Of Medication Or Pills? ☐Yes ☐No
   If Yes, Which Ones And For What Purposes? Please Explain: ____________
6. Do You Have Any Allergies ☐Yes ☐No
   If Yes, Please Explain: ____________
   Are You Allergic To Any Medications? ☐Yes ☐No
   If Yes, Please Explain: ____________
7. Do You: Smoke? ☐Yes ☐No Drink Alcohol? ☐Yes ☐No
   Are You Dependent on prescription or recreational drugs? ☐Yes ☐No
   If Yes, What Drug? ____________
8. Do You Currently Wear Glasses? ☐Yes ☐No
   If Yes, Would You Like Your Lenses To Be (please check all that apply)
   ☐Thinner ☐Lighter ☐More Impact Resistant ☐Glare Free
   ☐Sensitive To Light Conditions (Transitions)
9. Do You Wear Glasses For: ☐Distance ☐Reading ☐Constant Wear ☐Don't Wear Glasses
10. Do You Currently Wear Bifocals? ☐Yes ☐No
    If yes, Would You Like To See Clearly At All Distances While Eliminating The Visible Bifocal Line? ☐Yes ☐No
11. Do You Participate In Sports, Recreational or Outdoor Activities, Especially Around Snow And Water? ☐Yes ☐No
12. Do You Currently Wear Contact Lenses? ☐Yes ☐No
    If No, Would You Be Interested In Contact Lenses? ☐Yes ☐No
    If Yes, What Type of Lens Are You Currently Wearing?
    ☐Rigid Gas Permeable ☐Soft Lens
13. Have You Ever Considered Laser Vision Correction (Lasik) ☐Yes ☐No
14. How Many Hours Do You Work On A Computer? ____________
    Are You Experiencing Any Of The Following:
    ☐Eye Strain ☐Backaches ☐Neck Strain ☐Headaches

Section 2 - Notice Of Privacy Practices

To be completed by the individual receiving the Notice of Privacy Practices

I, ____________, acknowledge that I have received the Privacy Practices Notice.

Signature ____________ Date______

If this authorization is signed by a personal representative on behalf of the individual, complete the following

Personal Representative Name ____________

Relation To Individual ____________

Section 3 - IMPORTANT! Please Read And Sign

1. We provide spectacle lenses that meet or exceed American National Standards Z80.1/Z78.1 and FDA requirements 21 CFR 801.410 for impact resistance. No lens material available today is unbreakable or shatterproof. Of all lens materials that lenses are made from, Polycarbonate, Plastic and Glass, **POLYCARBONATE HAS BEEN RECOGNIZED AS ONE OF THE MOST IMPACT RESISTANT.**
2. **DILATED EYE EXAMINATION INFORMATION** Dilation is a medical procedure, which allows the doctor to use eye drops to temporarily enlarge your pupils for a more extensive view of the retina (back of the eye). With dilation, the doctor has the opportunity to evaluate and diagnose eye health problems It is recommended that all new patients are dilated and again every 2 to 4 years thereafter, unless certain conditions require closer monitoring. Some patients may experience light sensitivity and blurred vision for 2-6 hours. If you do not have dark sunglasses for your travel home, we will provide you with a disposable pair. You may have difficulty driving after the procedure, please make arrangements to be driven home.
   In rare instances, patients may experience pain or other side effects. If this should occur, seek medical attention immediately. Please advise our optometrist if you are pregnant or nursing at the time or have any other health conditions that may effect your response to these tests or questions regarding dilation, please consult our doctor for additional information.
3. **PAYMENT POLICY** Payment for eye examinations, contact lens examinations, contact lens checks and continuing eye care plans is required at time of services provided. A deposit of 100% is required to order eyeglasses or contact lenses.
4. **PAYMENT POLICY AFTER INSURANCE** 100% of patient balance is required after insurance benefit is applied.
5. **AUTHORIZATION OF PAYMENT AND PATIENT RELEASE I authorize the direct payment of medical/vision benefits for all services rendered.**
   I accept financial responsibility for any unpaid balances not covered by my Vision Care Program for services rendered to me, my spouse, and/or my dependants. I authorize the release of any medical or other information necessary to process this claim.

I HAVE READ AND UNDERSTAND STATEMENTS 1-5

Patient's Signature ____________ Date / /

Guardian Signature ____________ Date / /