



Name: _____

Cell Phone: (____) _____

E-Mail: _____

(EP)

WHAT IS THE REASON FOR TODAY'S VISIT? (Check all that apply)

- I have an Eye Disease or Eye Problem requiring examination: _____
I want Glasses
I want Contact Lenses:
Rate 1-10 how happy you are with your contact lenses (Circle one) not happy 1-2-3-4-5-6-7-8-9-10 very happy
I am interested in Lasik Refractive Surgery or Corneal Refractive Therapy
How soon? (Circle One) 1mo. 3mo. 6mo. 1yr. Undecided
I am here for my Annual Eye Health and Vision Evaluation

DO YOU EXPERIENCE ANY OF THE FOLLOWING? (Check all that apply)

Table with 3 columns: Distance vision blurred w/ glasses/contacts, Dry/ Burning eyes, See flashing lights, etc.

INSURANCE Has your VISION or MEDICAL insurance changed? Y N
Do you have a secondary vision insurance? Y N

Eligibility and verification of benefits does not guarantee payment. I understand that I am responsible for any unpaid claims or payments, including those applied to my annual deductible.

PATIENT SIGNATURE (If under 18, parent signature required)

DATE

To our Contact Lens wearing Patients:

As is common in the eye care industry, we charge annual re-evaluation and re-fitting fees. The annual re-evaluation fee ranges from \$49 - \$69. If we need to change brands, then the re-fitting fee ranges from \$99 - \$219. This fee covers all contact lens follow-ups and any contact lens related eye problems for one year.

I understand the above contact lens policy: _____

Thank You!

For Office Use Only:

Vision (VF FDT ??)

initial Exam

CC/ROS WRx: (SVD /SVN /SVI /BF /TF /PALs) 20/
Happy with (GL / CL / VA) OD 20/
Blurred Vision (OD/OS) (D/C/N) (GL/CL) OS 20/
(M/Mod/Sev) (1/2/3/4/5/6 y/m/w/d) Add
WRx: (SVD /SVN /SVI /BF /TF /PALs)
Medical History No Meds/ No Allergy OD 20/
Meds: BP/Chol/Diab/Om3/AT OS 20/
Allergy: asp/cip/iod/pen/sul Add
Diab: act/ava/gli/glu/gly/ins/jan/met/tru/vic/xig VA (corr / uncorr) 20/
HBP: aml/asp/ate/car/coz/dio/fur/hyd/lis/los/lot/met/top 20/
Chol: cre/lip/lov/prasim/vyt/zet/zoc Thy: lev Arth: hum/plaq Asth: alb/flo/sin All: all/cla/flo/zyr DES: lot/res/xii