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."