

# Rich Vision Welcome To Our Office

Mr.  Miss  Mrs.  Ms.

Male  Female

\_\_\_\_\_  
First Name MI Last Name Preferred Name

\_\_\_\_\_  
Street Address City State Zip

\_\_\_\_\_  
Social Security Number Date of Birth Home Phone - Include Area Code Work Phone

\_\_\_\_\_  
Email Address Spouse or Parent(s) Name Person Responsible for Account

\_\_\_\_\_  
Emergency Contact Emergency Phone

How were you referred to our office?

Phone Book  School  Advertisement  Patient (Please Name) \_\_\_\_\_  
 Insurance Listing  Drive by  Other \_\_\_\_\_  Doctor (Please Name) \_\_\_\_\_

\_\_\_\_\_  
Name and Address of Primary Insurance Company City State Zip

M  F

\_\_\_\_\_  
Insured's First Name MI Insured's Last Name

## PRIMARY INSURANCE INFORMATION

\_\_\_\_\_  
Insured's Identification Number Group Number

\_\_\_\_\_  
Insured's Date of Birth

### Patient Relationship to Insured

Self  Spouse  Child  Other

### Patient Status

Single  Married  Other  
 Full Time Student  Part Time Student  Employed

## SECONDARY INSURANCE INFORMATION

\_\_\_\_\_  
Name and Address of Secondary Insurance Company City State Zip

M  F

\_\_\_\_\_  
Insured's First Name MI Insured's Last Name

### Patient Relationship to Insured

\_\_\_\_\_  
Insured's Identification Number Group Number Insured's Date of Birth  Self  Spouse  Child  Other

## Please Read:

In order to control the cost of billing, we ask that the patient's portion is paid at the time services are rendered unless other arrangements are made in advance. We would rather control billing costs than be forced to raise our fees. All professional services and material are charged to the patient. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Accounts 90 days old are subject to collection fees. There will be a service charge on all returned checks.

Payment from my insurance is to be paid directly to . I understand that will be billed as my primary insurance. I understand that billing any secondary insurance is my responsibility. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Name

# Rich Vision PATIENT HISTORY AND INFORMATION

## PRIMARY CARE PHYSICIAN

Primary Care Physician and Clinic Name

Address of Primary Care Physician

City

State Zip

Phone

## REFERRING PHYSICIAN

Referring Physician and Clinic Name

Address of Referring Physician

City

State Zip

Phone

## HEALTH HISTORY

What is the main reason for today's exam ? \_\_\_\_\_ When was your last exam ? \_\_\_\_\_

When was your last health exam ? \_\_\_\_\_

Past Illnesses or Injuries: \_\_\_\_\_

Past Surgeries: \_\_\_\_\_

Current Medications: \_\_\_\_\_

Current Eye Drops: \_\_\_\_\_

Medicines that cause reactions or sensitivities: \_\_\_\_\_

Specific Allergies: \_\_\_\_\_

## EYE HISTORY

Glaucoma	<input type="radio"/> Yes <input type="radio"/> No	Dryness	<input type="radio"/> Yes <input type="radio"/> No	Strabismus (Crossed Eyes)	<input type="radio"/> Yes <input type="radio"/> No
Cataract	<input type="radio"/> Yes <input type="radio"/> No	Excess Tearing/Watering	<input type="radio"/> Yes <input type="radio"/> No	Blurred Vision Distance	<input type="radio"/> Yes <input type="radio"/> No
Macular Degeneration	<input type="radio"/> Yes <input type="radio"/> No	Eye Pain or Soreness	<input type="radio"/> Yes <input type="radio"/> No	Blurred Vision Near	<input type="radio"/> Yes <input type="radio"/> No
Retinal Detachment	<input type="radio"/> Yes <input type="radio"/> No	Foreign Body Sensation	<input type="radio"/> Yes <input type="radio"/> No	Distorted Vision (halos)	<input type="radio"/> Yes <input type="radio"/> No
Color Blindness	<input type="radio"/> Yes <input type="radio"/> No	Infection of Eye or Lid	<input type="radio"/> Yes <input type="radio"/> No	Double Vision	<input type="radio"/> Yes <input type="radio"/> No
Headaches	<input type="radio"/> Yes <input type="radio"/> No	Itching	<input type="radio"/> Yes <input type="radio"/> No	Floaters or Spots	<input type="radio"/> Yes <input type="radio"/> No
Glare/Light Sensitivity	<input type="radio"/> Yes <input type="radio"/> No	Mucous Discharge	<input type="radio"/> Yes <input type="radio"/> No	Fluctuating Vision	<input type="radio"/> Yes <input type="radio"/> No
Tired Eyes	<input type="radio"/> Yes <input type="radio"/> No	Drooping Eyelid	<input type="radio"/> Yes <input type="radio"/> No	Loss of Vision	<input type="radio"/> Yes <input type="radio"/> No
Amblyopia (Lazy Eye)	<input type="radio"/> Yes <input type="radio"/> No	Redness	<input type="radio"/> Yes <input type="radio"/> No	Loss of Side Vision	<input type="radio"/> Yes <input type="radio"/> No
Burning	<input type="radio"/> Yes <input type="radio"/> No	Sandy or Gritty Feeling	<input type="radio"/> Yes <input type="radio"/> No		

## GENERAL HEALTH CONDITION

Fever	<input type="radio"/> Yes <input type="radio"/> No	Respiratory (Asthma)	<input type="radio"/> Yes <input type="radio"/> No	Anxiety or Depression	<input type="radio"/> Yes <input type="radio"/> No
Weight Loss	<input type="radio"/> Yes <input type="radio"/> No	Gastrointestinal	<input type="radio"/> Yes <input type="radio"/> No	Endocrine (Thyroid, Diabetes)	<input type="radio"/> Yes <input type="radio"/> No
Other Symptoms	<input type="radio"/> Yes <input type="radio"/> No	Kidney	<input type="radio"/> Yes <input type="radio"/> No	Blood/Lymph	<input type="radio"/> Yes <input type="radio"/> No
Ears,Nose,Throat	<input type="radio"/> Yes <input type="radio"/> No	Muscles,Bones,Joints	<input type="radio"/> Yes <input type="radio"/> No	Allergic	<input type="radio"/> Yes <input type="radio"/> No
Cardiovascular (high blood pressure etc.)	<input type="radio"/> Yes <input type="radio"/> No	Skin	<input type="radio"/> Yes <input type="radio"/> No	Are you?	<input type="checkbox"/> Pregnant
Neurological (Multiple Sclerosis)	<input type="radio"/> Yes <input type="radio"/> No				<input type="checkbox"/> Nursing

## FAMILY HISTORY

Amblyopia (Lazy Eye)	<input type="radio"/> Yes <input type="radio"/> No	Retinal Detachment	<input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No
Blindness	<input type="radio"/> Yes <input type="radio"/> No	Strabismus (Eye Turn)	<input type="radio"/> Yes <input type="radio"/> No	Kidney Disease	<input type="radio"/> Yes <input type="radio"/> No
Cataract(s)	<input type="radio"/> Yes <input type="radio"/> No	Arthritis	<input type="radio"/> Yes <input type="radio"/> No	Lupus	<input type="radio"/> Yes <input type="radio"/> No
Color Blindness	<input type="radio"/> Yes <input type="radio"/> No	Cancer	<input type="radio"/> Yes <input type="radio"/> No	Stroke	<input type="radio"/> Yes <input type="radio"/> No
Glaucoma	<input type="radio"/> Yes <input type="radio"/> No	Diabetes	<input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease	<input type="radio"/> Yes <input type="radio"/> No
Macular Degeneration	<input type="radio"/> Yes <input type="radio"/> No	Heart Disease	<input type="radio"/> Yes <input type="radio"/> No	Others	<input type="radio"/> Yes <input type="radio"/> No

Name \_\_\_\_\_

# Rich Vision MEDICAL HISTORY QUESTIONNAIRE

## SOCIAL HISTORY

Current Occupation : \_\_\_\_\_ Years \_\_\_\_\_ Employer \_\_\_\_\_

## SPECTACLE LENS HISTORY

Do you use a computer?       Yes    No   How many hours/day? \_\_\_\_\_   Distance from Computer? \_\_\_\_\_  
Do you drive?    Yes    No   Mileage to work each way? \_\_\_\_\_   Do you have glare problems?    Yes    No

Do you have visual difficulty when driving?       Yes    No  
Do you have problems with night vision?       Yes    No

Do you currently wear glasses ?       Yes    No   Since \_\_\_\_\_

Type of glasses       Full Time    Part Time    Distance    Close

Glasses Owned

Single Vision    Bifocals    Trifocals    Back-up Glasses    Safety Glasses    Sports Glasses    Progressive

Have you had trouble in the past with glasses?       Yes    No \_\_\_\_\_

Do you wear sunglasses?       Yes    No   Are your sun glasses your current prescription ?    Yes    No

## SPECIAL EYEWEAR NEEDS

Computer (special prescriptions, special anti-glare tints or coatings)    Safety Glasses (gardening, woodworking, welding)  
 Occupational (mechanics, plumbers, pilots)    Sports/Hobbies (racquet sports, motorcycle)

## CONTACT LENS HISTORY

Have you ever tried to wear contact lenses?       Yes    No   Reason for stopping? \_\_\_\_\_

Do you currently wear contact lenses?       Yes    No   Since \_\_\_\_\_

If not a contact lens wearer, are you interested in trying contact lenses at this time ?       Yes    No

How many hours/day ? \_\_\_\_\_   How many days/week ? \_\_\_\_\_   Today's wearing time ? \_\_\_\_\_

Type and brand of contact lenses \_\_\_\_\_

## Please rate the following on a scale of 1-10, with 1 being POOR to 10 being EXCELLENT

	Right	Left		Right	Left		Right	Left	
Lens Comfort	_____	_____	Distance Vision	_____	_____	Near Vision	_____	_____	
What Solutions do you use?			Cleaner	_____		Disinfectant	_____	Enzyme	_____

## SOCIAL HISTORY

Do you use nutritional supplements (vitamins etc.)?       Yes    No

Do you engage in regular exercise?       Yes    No

Do you drink alcohol ?      If yes, how much/often :    No    Occasional    1 per day    2-3/day    4+/day

Do you smoke ?      If yes, how much/often :    No    Occasional    1/2 pack/day    1 pack/day    1+ pack

Method of Tobacco Intake :       Smoking    Chewing

Do you use Illegal Drugs :       Yes    No

Hobbies/ Interests : \_\_\_\_\_