

Vision Health Eyecare Center
Dr. Don Vanderfeltz & Associates

Today's Date _____

Patient Information

Miss Mrs. Ms. Mr. Dr. Rev.
Last _____
First _____ MI _____
Street _____
City _____ State _____
Zip _____
Home Phone _____
Work Phone _____
Cell Phone _____
Date of Birth _____ Age _____
Sex M F
Patient's SSN _____
Employer (or school) _____
Occupation (or grade) _____
Spouse (or Parent's Name) _____
Email Address _____

What is the major purpose of this visit?

Any problems with your current contact lenses or glasses?

VERY IMPORTANT! NEW PATIENTS ONLY:

Whom may we thank for referring you to our office?

If not referred, how did you choose our office?

- ___ Another Doctor
- ___ Insurance List
- ___ Saw Sign/Building
- ___ Newspaper/Radio
- ___ Yellow Pages: Which Directory?

Lifetime Signature

I request that payment of authorized Medicare benefits or other insurance be made either to me or on my behalf to Vision Health Eyecare Center for any services furnished to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I also understand that I am responsible for any balance due if insurance does not pay.

Signature

HIPAA

I acknowledge that I am aware of Vision Health Eyecare Center's Notice of Privacy Practices.

Patient Name _____

Welcome To Our Office

Insurance Information

Please note that insurance does NOT cover the Contact Lense Care Agreement.

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

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

Do you participate in a flex spending plan?
___ Yes ___ No

How will you settle your account today?
___ Cash ___ Check ___ Credit Card

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?
 - ___ 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 Rx
 - ___ have children?
 - ___ have family members in need of eyecare?

Signature _____

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 exam _____

CURRENT MEDICATIONS:
(Rx and Over the Counter)

Allergies to Medications? Yes No
If so, what medications?

Have you had any surgeries? Yes No

Are you currently pregnant?
Yes No

Do you use cigarettes/tobacco, alcohol, or other
Substances? Yes No
(Circle if your answer is yes)

Have you ever been diagnosed or treated for the
following conditions?

- | | |
|---|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Blood/Lymph | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Cholesterol |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Digestive |
| <input type="checkbox"/> Ears/Nose/Throat | <input type="checkbox"/> Endocrine |
| <input type="checkbox"/> Eczema/Rashes | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Fevers | <input type="checkbox"/> Urinary |
| <input type="checkbox"/> High Blood pressure | <input type="checkbox"/> Skin problems |
| <input type="checkbox"/> Kidney | <input type="checkbox"/> Muscle/Bone |
| <input type="checkbox"/> Neurological | <input type="checkbox"/> Psychological |
| <input type="checkbox"/> Respiratory | <input type="checkbox"/> Sinus |
| <input type="checkbox"/> Throat Infections | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Unusual Weight loss/gain | |

Patient Eye History

Date of Last Eye Exam _____

By Whom? _____

Have you ever tried contact lenses?

Yes No

Do you currently wear contact lenses?

Yes No

What Kind? _____

Solution Used? _____

Are you satisfied with the vision and
comfort of your lenses? Yes No

Would you prefer clear or color contacts?
 Clear Colored

If you wear bifocals, do the lines or head
tilting bother you? Yes No

Family Medical/Eye History

(Check all that apply)

Relationship (Mother or Father's side) _____

Blindness _____

Cataracts _____

Glaucoma _____

Macular Degeneration _____

Retinal Disease/detachment _____

Lazy Eye/Crossed Eyes _____

Diabetes _____

Cancer _____

High Blood pressure _____

Heart Disease _____

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 Abrasion |
| <input type="checkbox"/> Crossed eyes | <input type="checkbox"/> Double Vision |
| <input type="checkbox"/> Eye Infections | <input type="checkbox"/> Serious 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"/> Tearing | <input type="checkbox"/> Occasional dryness |
| <input type="checkbox"/> Night Vision | <input type="checkbox"/> Light Sensitivity |
| <input type="checkbox"/> Macular Degeneration | |
| <input type="checkbox"/> Retinal Detachment | |
| <input type="checkbox"/> Uncomfortable glasses | |
| <input type="checkbox"/> Other eye disorders | _____ |