Welcome to Our Office!

Patient Last Name_____, First _____ MI _____

DOB ____/____/_____ Age_____ Sex M F Marital Status M S W SSN #_____

Address_____ City _____

State_____ ZIP _____ Occupation/Employer_____

E-mail_____

Phone: Home (_____) _____ Work (_____) _____ Cell (_____) _____

Vision Insurance Carrier _____ Member #_____

Medical/Health Insurance Carrier_____ Member Name_____
DOB of Member ___/____/_____ Relationship to Member: Self Spouse Child

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Who do we have to thank for ***referring*** you to our office**?** _____
Did you see any advertisement for Westbrook Vision Center? _____

Last **Eye Exam** _____ Where/Doctor_____ Last **Physical Exam** _____

[ ] No [ ] Yes Are you interested in ***Contact Lenses*****?**
[ ] No [ ] Yes Have you worn Contact Lenses? If so, what type? (Please circle all that apply)
Soft Disposable Daily Wear Extended Wear Toric Multi/bifocal Hard/gas perm
[ ] No [ ] Yes Are you interested in ***Refractive Surgery*** **(LASIK)**?
[ ] No [ ] Yes Have you had ***eye surgery*****?** Cataract, LASIK, RK, Eye Muscle, Other_____
If so, when? _____

Present History

Please check the symptoms you are experiencing:
[ ] Blurred vision at Distance [ ] Eye Discomfort/Irritation [ ] Redness [ ] Dryness [ ] Itching
[ ] Blurred Vision at near [ ] Tired Eyes [ ] Eye Pain [ ] Sore eyes [ ] Double Vision
[ ] Headaches [ ] Other Concerns_____
[ ] No [ ] Yes Do you suffer from ***seasonal allergies***? Do they affect your eyes? _____
[ ] No [ ] Yes Do you use a ***computer***? Approximate # of hours per day? _____
[ ] No [ ] Yes Have you been diagnosed with ***eye problems***?
[ ] Cataract [ ] Glaucoma [ ] Macular Degeneration [ ] Dry Eye
Other/explain _____
[ ] No [ ] Yes Are you ***taking any medications***? (Include vitamins):_____
_____
[ ] No [ ] Yes Do you have any ***allergies to medications***? (List)_____

Family History

[ ] No [ ] Yes has anyone ***in your family*** been diagnosed with any of the following conditions listed below?
[ ] Blind [ ] Cataract [ ] Glaucoma [ ] Macular Degeneration [ ] Retinal Problems
[ ] Diabetes [ ] Hypertension
[ ] Other/Explain_____
Is there anyone else in your family in need of our services? _____
_____

Please Turn Page Over **– Additional Question are on Reverse Side**

Social History (**All information on this form is strictly confidential**)

[ ] No [ ] Yes Do you use tobacco products? What type and how many years? _____
[ ] No [ ] Yes Do you drink alcohol?
[ ] No [ ] Yes Do you use any illegal drugs? _____
[ ] No [ ] Yes Have you been diagnosed with [ ] HIV/AIDS [ ] Gonorrhea [ ] TB [ ] Hepatitis [ ] Chlamydia [ ] Herpes [ ] Syphilis

Review of Systems: Please indicate your response with a check mark below.

Constitutional [ ] None
[ ] Developmental disability
[ ] Weight Gain / Weight Loss
[ ] Fever
[ ] Fatigue

Ear, Nose, & Throat [ ] None
[ ] **Allergies** / Hay fever
[ ] Ear Infection
[ ] Sinus congestion

Cardiovascular [ ] None
[ ] Heart Attack
[ ] Hypertension/**High blood press**
[ ] Congestive Heart Failure
[ ] Arrhythmia
[ ] High Cholesterol
[ ] Aneurysm
[ ] Pacemaker

Respiratory [ ] None
[ ] **Asthma**
[ ] Bronchitis
[ ] Emphysema
[ ] COPD
[ ] Lung Cancer

Gastrointestinal [ ] None
[ ] Crohn's Disease
[ ] Colitis
[ ] Ulcer
[ ] Digestive Problems

Genitourinary [ ] None
[ ] Urinary tract infection (UTI)
[ ] Kidney infection / disease
[ ] STD/Herpes/Chlamydia
[ ] Ovarian/prostate cancer

Musculoskeletal [ ] None
[ ] Fibromyalgia
[ ] Muscular Dystrophy
[ ] Arthritis
[ ] Ankylosing Spondylitis
[ ] Lupus

Integumentary/Skin [ ] None
[ ] Eczema
[ ] Rosacea acne
[ ] Psoriasis
[ ] Skin Cancer

Neurological [ ] None
[ ] Multiple Sclerosis
[ ] Alzheimer's
[ ] Seizures
[ ] Stroke/CVA
[ ] Parkinson's

Psychiatric [ ] None
[ ] Depression
[ ] Panic Disorder
[ ] Schizophrenia
[ ] Drug Dependence

Endocrine [ ] None
[ ] **Diabetes**
[ ] Thyroid Dysfunction
[ ] Pituitary Dysfunction
[ ] Hormonal Dysfunction

Liver / Lymph System [ ] None
[ ] Anemia
[ ] Leukemia
[ ] Bleeding Disorder

Allergic / Immunologic [ ] None
[ ] Drug allergies
[ ] Environmental allergy
[ ] Rheumatoid arthritis
[ ] Lupus
[ ] AIDS
[ ] HIV

Women
[ ] Breast Cancer
[ ] Hysterectomy

If you answered **YES** to any of the above or have any condition not listed, please explain: _____
_____
_____

Method of Payment: [ ] Cash [ ] Check [ ] Visa [ ] MC [ ] Am Express

I, the patient, authorize any holder of medical/optical information to release information about me to other health care professionals, attorneys, or insurance companies via mail or electronic transmission. I authorize and request that payments made under my insurance plan be made directly to Westbrook Vision Center PLC for services furnished to me. Contact lens prescriptions are not released until after the initial fitting and follow-up care is complete. **Waiver of Liability –** Medicare will only pay for services considered to be "reasonable & necessary". Medicare may deny payment for services (exam for glasses/contacts, visual field screening, contact lenses, photos, etc.). Therefore, you, "the patient" is personally fully responsible for payment in the event your insurance denies reimbursement.

I have read and understand the above information.

→ Signature _____ Date _____/_____/20_____