WELCOME TO OUR OFFICE
PLEASE COMPLETE AND SIGN THIS FORM

Last name: _____ First name: _____**Male/Female**
Date of birth _____Tel (home and cell): _____
Address: _____ City_____ Zip Code: _____
Insurance carrier: _____ Policy Holders Name: _____

The **main reason** for my visit today is (please circle):

Medical Eye Problem. Glasses Exam. Contact Lens Exam **Both** glasses and contact lens exam.

Contact lens examinations are **different** from glasses examinations. The cost of a contact lens exam is $90.

I have worn contact lenses before YES NO I plan to get glasses today YES NO
I wear prescription sunglasses YES NO

I have the following general health problems for which I'm under care of my physician (example: diabetes, blood pressure, etc)_____

I take the following medications:_____

I am **allergic** to the following medications:_____

Circle any that apply

I have --- Double vision Severe headaches Big flashes of light Floaters Recent eye injury
My eyes sometimes --- Itch Tear Burn Get red Feel dry
Sometimes I --- Drive a car Work at a computer Use Tobacco Products
My blood relatives have: Diabetes High blood pressure Cancer Eye operations Medications for the eyes

A Note About Refraction

Refractive analysis is the procedure the doctor performs to determine the correct prescription in glasses to achieve your best vision. This is usually considered part of a routine vision examination, as opposed to medical eye care when there is a problem with the eyes. Contact lens examinations are **different** from refractions. **The cost of a contact lens exam is $90.**

Medicare and most other medical plans do not cover routine care services, just medical problems with the eye. Because of insurance regulations, **there will be a separate, $25 charge for refractions when they are performed during your medical examination**.

Some patients have separate routine vision care coverage that would reimburse for this part of the exam. If you have separate routine vision care coverage (optical plan), please tell the front desk staff **before** the examination.

Our Notice of Privacy Practices

Your personal health information is private. We value your privacy and will not share any information without your permission. Copies of Privacy Rules and Practices are available upon request.

Signature_____ Date_____