~Encore Vision Centers~

Welcome to our office!

PATIENT INFORMATION

Last Name: ______________________________ First Name: ____________________________ MI: __________________
Address: ____
City: ____ State: _____________________ Zip: _________________________
Birth Date: ___________________________ Sex: M__F___ Social Security #_____________________________________
Primary Phone: _______________________ Secondary Phone: ____
Email Address: ____
Employer: _____________________________________Occupation:____
Student: Y____N____, If Yes, Full-Time__________ Part-Time_________
Responsible Party Name: ____ Relationship: _________________________
Emergency Contact: ____ Phone #: ___________________________________
Were you referred to us? If so, by whom? ____

INSURANCE INFO:

Vision Insurance Carrier: ____ I.D. # ___________________________________
Major Medical Insurance: ____ I.D. #___________________________________
Primary Insured: ____________________________Relationship to Patient: ____

PATIENT OCULAR INFORMATION

Last Complete Eye Exam: ________________________Where? _______________________________ Dilated? Y_____N____
Reason for Today's Visit:____
Have you ever had an eye injury and/or surgery? If yes, describe and provide date _______________________________________
____
Do you wear Glasses? Y____N____ How Long? __________________________ Far Vision? Near Vision? Both?
Do you wear Contact Lenses? Y _____ N_____ How Long? ___________ Type ___________________________________
Have you ever been diagnosed with **Cataracts?** Y / N **Glaucoma?** Y / N **Retinal Detachment?** Y / N **Lazy Eye?** Y / N
Floaters? Y / N **Macular Degeneration?** Y / N **Other Diagnosis?** ____
Do you ever experience any of the following? (please circle any that apply): **Blurring Double Vision Dryness Tearing Headaches Haloes Eye Pain Redness Vision Loss Burning Light Sensitivity Reduced Night Vision Flashes/Floaters Other** ____
Do you drive? Y / N Any difficulty when driving? Y /N, If yes, explain: ____
Do you use a computer? Y /N For Work? Y / N How many hours per day? ____
Do you use a computer for personal use? Y/ N How many hours per day? ____
Any visual difficulty with computer use? Y / N, If yes explain: ____
Any hobbies with vision difficulties or special visual needs? Y / N, If yes, explain: ____

****Please indicate if any of the following are topics you wish to discuss with the Doctor.**
~Spectacles- UV Radiation, Computer Use, Sports, No-Line Bifocals
~Contact Lenses- Bifocals, Daily Wear, Extended Wear, Disposables
~Ocular Health- Dry Eye Treatment Options, Ocular Surgery

FAMILY HISTORY

Please indicate below any diagnosis or condition you or immediate family member has or had, along with relationship to patient
CANCER/TUMORS ______________ CATARACTS ______________ DIABETES _______GLAUCOMA______________
HEART DISEASE ________________ HIGH BP __________________ LAZY EYE _________________ MS ___________
RETINAL DETACHMENT _________________THYROID DISEASE __________________ARTHRITIS _____________
BLINDESS________________ MACULAR DEGENERATION _______________ OTHER ___________________________________

PERSONAL MEDICAL INFORMATION

Last complete Physical Examination? ______________________________Primary Care Physician? __________________________
Have you ever had an adverse drug reaction? Y / N, if yes, please explain: ________________________________
List current medications/vitamins (RX and OTC): ________________________________
____
Are you pregnant? Y / N, if yes, wks/mos? ___________________________ Are you nursing? Y / N
Please Indicate if any of the following are symptoms/diagnosis you have presently or have ever had:

Headaches	Y	N	Migraines	Y	N	Seizures	Y	N
Chronic Cough	Y	N	Dry Mouth	Y	N	Sinus Congestion	Y	N
Asthma	Y	N	Bronchitis	Y	N	Emphysema	Y	N
Heart Disease	Y	N	Vascular Disease	Y	N	High Blood Pressure	Y	N
Muscle Pain	Y	N	Joint Pain	Y	N	Rheumatoid Arthritis	Y	N
Anemia	Y	N	High Fever	Y	N	Hay Fever	Y	N
Skin	Y	N	Stroke	Y	N	Kidney Disease	Y	N
Diarrhea	Y	N	Constipation	Y	N	Bladder/Genitals	Y	N
Immunologic	Y	N	Psychiatric	Y	N	STD	Y	N
HIV	Y	N	Hepatitis	Y	N	Cancer/Tumors	Y	N
Hormonal	Y	N	Multiple Sclerosis	Y	N			

If you answered YES TO ANY of the above, please explain: ________________________________
____
Please list any additional condition(s), not listed: ________________________________
Have you been diagnosed with Diabetes? Y / N, if yes, list type and date of diagnosis: ________________________
Do you suffer from Allergies? Y /N, if yes, explain: ________________________________
Other health concerns: ________________________________
List all major surgeries or procedures and approx dates: ________________________________
____
Do you use tobacco products? Y / N Alcohol? Y / N Other Substances? Y / N
If yes, please explain? ________________________________

{All information that you provided is kept strictly confidential}

****CONTACT LENS WEARERS WITH INSURANCE:** Contact lens patients are responsible for the difference in fees between eye examination fees (paid by your insurance coverage) and our usual and customary contact lens examination fees.

****INSURANCE/MEDICARE PATIENTS: I authorize the release of any medical information that may be required to determine payable benefits for related services/materials, to my insurance carrier or the Health Care Financing Administration and/or it's agents. By signing below, patient/guardian understands that if the insurance company denies payment on a claim, patient/guardian is responsible for payment.**

Patient/Guardian Signature____ Date: _____/______/_______

Doctor's Review ____Date: _______/________/_____