

# WELCOME TO OUR OFFICE

Today's date \_\_\_\_\_

## Patient Information:

Last name \_\_\_\_\_ First name \_\_\_\_\_ MI \_\_\_\_\_

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Sex M F SSN \_\_\_\_\_

Home Phone \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_ e-mail \_\_\_\_\_

Employer (or school) \_\_\_\_\_ Occupation (or grade) \_\_\_\_\_

Spouse (or parent's) name \_\_\_\_\_ Spouse (or parent's) work \_\_\_\_\_

Do you have any of the following insurance plans: **Anthem** **Cox Health Plans** **Healthlink** **Medicare**  
**MO Healthnet** **Premier** **Fee for Service** **VCD** **VSP**

## Medical History:

Name of Family physician \_\_\_\_\_

Town \_\_\_\_\_ Date of last Physical Exam \_\_\_\_\_

Current Medications: (Rx or OTC. Including eye drops, vitamins and birth control pills) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List any drug allergies: \_\_\_\_\_

### Have you had:

- |   |   |
|---|---|
| <input type="checkbox"/> Allergic/Immune disease  | <input type="checkbox"/> Heart Trouble            |
| <input type="checkbox"/> Arthritis                | <input type="checkbox"/> High Blood Pressure      |
| <input type="checkbox"/> Asthma/Respiratory prob. | <input type="checkbox"/> Muscle/Bone Disease      |
| <input type="checkbox"/> Blood Disease            | <input type="checkbox"/> Neurologic problem       |
| <input type="checkbox"/> Cancer                   | <input type="checkbox"/> Psychiatric problem      |
| <input type="checkbox"/> Cholesterol              | <input type="checkbox"/> Recent Fever/Weight Loss |
| <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> Skin Disease             |
| <input type="checkbox"/> Ear/Nose/Throat problem  | <input type="checkbox"/> Tested HIV positive      |
| <input type="checkbox"/> Gastrointestinal problem | <input type="checkbox"/> Thyroid/Endocrine prob   |

## Eye History:

Date of last eye exam \_\_\_\_\_ By whom? \_\_\_\_\_

Dates and type of any previous eye surgeries: \_\_\_\_\_  
\_\_\_\_\_

Have you ever tried contact lenses?  Yes  No

Do you currently wear contact lenses?  Yes  No

What kind? \_\_\_\_\_

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

Do you currently wear glasses?  Yes  No

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

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

### Have **you** or **any in your family** had:

- |                         | Myself                   | Family(relationship)           |
|-------------------------|--------------------------|--------------------------------|
| Cataracts               | <input type="checkbox"/> | <input type="checkbox"/> _____ |
| Crossed/Lazy eye        | <input type="checkbox"/> | <input type="checkbox"/> _____ |
| Double vision           | <input type="checkbox"/> | <input type="checkbox"/> _____ |
| Eye injury              | <input type="checkbox"/> | <input type="checkbox"/> _____ |
| Glaucoma                | <input type="checkbox"/> | <input type="checkbox"/> _____ |
| Iritis                  | <input type="checkbox"/> | <input type="checkbox"/> _____ |
| Itchy/burning eyes      | <input type="checkbox"/> | <input type="checkbox"/> _____ |
| Macular degeneration    | <input type="checkbox"/> | <input type="checkbox"/> _____ |
| Retinal detachment      | <input type="checkbox"/> | <input type="checkbox"/> _____ |
| Sunlight Sensitivity    | <input type="checkbox"/> | <input type="checkbox"/> _____ |
| Trouble seeing at night | <input type="checkbox"/> | <input type="checkbox"/> _____ |
| Other eye disorders     | _____                    | _____                          |

## Lifestyle Questions:

What is the major purpose of this visit? \_\_\_\_\_  
\_\_\_\_\_

Are you planning on new glasses today? \_\_\_\_\_

Do you work at a computer?  Yes  No

Do you think you might benefit from thinner, lighter lenses?  Yes  No

Do you spend much time outdoors?  Yes  No

Do you have prescription sunwear?  Yes  No

Do you want more information on Laser Vision Correction surgery?  Yes  No

Do you have more than one pair of current Rx eyewear?  Yes  No

Do you have family members in need of eyecare?  Yes  No

## Important! New patients only:

Who may we thank for referring you to our office?

Name of friend or relative \_\_\_\_\_

If not referred, how did you choose our office?

- |  |   |
|--|---|
| <input type="checkbox"/> Another Dr.       | <input type="checkbox"/> Yellow pages       |
| <input type="checkbox"/> Insurance list    | <input type="checkbox"/> Web page           |
| <input type="checkbox"/> Saw sign/Building | <input type="checkbox"/> Newspaper/Radio/TV |

Please be advised if you are using insurance coverage for today's visit, this is a contract between you and your insurance company, not Ozarks Family Vision Centre. As a courtesy to you, we will file your insurance. However, you are responsible for your copays, co-insurance, deductible and any balance your insurance does not pay.

Signature \_\_\_\_\_