SHADOWRIDGE FAMILY VISION CENTER
WELCOME TO OUR OFFICE!

In order to fully assess your visual needs, please completely answer the following questions. We hope your visit will be rewarding and educational.

TODAY'S DATE ___________________

Mr. / Mrs. / Ms / Miss / Dr

PATIENT'S NAME ____________________________________ DATE OF BIRTH _______________

ADDRESS ____

CITY ____ ZIP CODE _______________________

HOME PHONE __________________________________ CELL PHONE _________________________

WORK PHONE _________________________ EMAIL ADDRESS ______________________________

OCCUPATION _______________________________ EMPLOYER _____________________________

BUSINESS ADDRESS ____

SOCIAL SECURITY # (if billing insurance) ____

DRIVER'S LICENSE # (if writing a check) ____

SPOUSE'S NAME ___________________________ OCCUPATION _____________________________

WHOM MAY WE THANK FOR YOUR REFERRAL?____

VISION INSURANCE? VSP (Vision Service Plan) MES EYEMED OTHER? ___________________

MAJOR MEDICAL INSURANCE? _______________________________HMO or PPO or OTHER
PRIMARY MEMBER'S NAME _______________________DOB____________RELATION__________
PRIMARY INSURANCE ID OR SOCIAL SECURITY NUMBER_________________________________

(Payment for professional services and materials is required at time of initial examination or office visit. If you have any questions, our office staff will be happy to assist you)

YOUR SIGNATURE AUTHORIZING US TO PERFORM SERVICES TODAY ____________________

IF A MINOR, PERSON RESPONSIBLE FOR PROFESSIONAL FEES? __________________________
RELATIONSHIP? __________________________
SIGNATURE AUTHORIZING PROFESSIONAL CARE FOR MINOR? __________________________

**** VISION HISTORY ****

Date of your last EYE exam? _______________________ Dr.'s Name ____________________
Please indicate the reason(s) you are here today:
___routine vision exam ___eye health exam ____new glasses _____new contact lenses ___other options
___LASIK interest _____ CRT contacts (new technology instead of LASIK)
Have you ever had eye surgery, disease, or a severe eye injury? Yes No
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Are you experiencing any of these issues?

TROUBLE SEEING:	ARE/DO YOUR GLASSES?	DO YOU WANT GLASSES FOR:
____ street signs	___ too heavy or thick	____driving ___ reading ___both
____ newspaper print	___ slide down your nose	____ computer ____ hobby
____ at night while driving	___ too scratched	____ sunglasses ____ sports
____ with bright sun/lights	____ cause many reflections	____ backup
____ while at the computer		
____ with a particular hobby		
____ other		

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****CONTACT LENSES****

What type/brand of contact lenses do you wear now?__________________________________
Are you happy with these lenses? Yes No If No, why? ___________________________
What solution do you use? ______________ Do you sleep in your contacts regularly? Yes No
Would you like to be able to sleep in contacts and not have to wear glasses or contacts the rest of the day?

Yes No Tell me more

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****MEDICAL HISTORY****

When was your last MEDICAL examination? _____________Dr.'s Name _________________
Results____
Do you have any health problems, if yes, please explain? _________________________________
____
Please list any medications you are taking ____
____
Please list any allergies you have including those to medications? ________________________

Any history in your family of the following?

High blood pressure ____ Glaucoma ____ "Lazy Eye" ____ Diabetes ____ Cataracts _____
Cancer ____ Thyroid condition_____ Macular Degeneration ____ Arthritis ____
Multiple Sclerosis ____

*Thank you for taking the time to complete this questionnaire.. Your answers will give us necessary information to provide a comprehensive optometric evaluation of your visual system related to your specific needs.