Signature Eye Center

WELCOME TO OUR OFFICE!

Patient Information

Today's Date ____________
Last Name ______________________________
First Name (legal) ____________________ MI ___
Preferred Name/Nickname ____________________
Street ______________________________
City ______________ State ________ Zip__________
Email: ______________________________
Used only for confirming appointments/orders, etc. No solicitations
Home Phone ______________________________
Work Phone ______________________________
Cell Phone ______________________________
Sex M F
Date of Birth __________________ Age ________
Patient's SSN ______________________________
Employer (or School) ______________________
Occupation (or Grade) ______________________
Spouse (or Parent's) Name ____________________
Spouse (or Parent's) Work ____________________

Who may we thank for referring you to our office?
Name of friend or relative ____________________
If not referred, how did you choose our office?
❑ Another Doctor ❑ Insurance List
❑ Saw Sign/Building ❑ Newspaper
❑ Yellow Pages
❑ Web Page: Which Web Site? ______________
❑ Other ______________________________

What is the major purpose of this visit?
(Glasses, Contact Lenses, Check-up, Red Eye, etc.)
____

Any problems with your current vision, contact lenses or glasses? Please explain (blurry far/near, strain, etc.)
____
____

Lifestyle Questions

Do you……(check box if your answer is yes)
❑..work at a computer for longer than 2 hours per day?
❑..think you might benefit from thinner, lighter lenses?
❑..spend a lot of time outdoors?
❑..have prescription sun glasses?
❑..prefer not to wear your glasses at times?
❑..want information on Laser Vision Correction surgery?
❑..have more than 1 pair of current Rx eyewear?
❑..have family members in need of eye care?
❑..play sports? Which sports?____________________
❑..have other hobbies? Explain____________________
❑..require safety glasses?

Payment & Insurance Information

How will you settle your account today?
❑ Credit/Debit Card (Visa, MC, Discover)
❑ Care Credit
❑ Cash (no checks)

Do you participate in a flex spending account?
❑ Yes ❑ No

Vision Insurance______________________________
Subscriber Name______________________________
Subscriber SSN________________________
Subscriber Birth Date__________________________

Primary Medical Insurance______________________
Subscriber Name______________________________
Subscriber SSN______________________________
Subscriber ID #____________ Group #____________
Subscriber Birth Date__________________________

Eye & Vision History

Date of Last Eye Exam__________________________
Doctor/Clinic/City?____________________________

❑ Blurry Vision ❑ Burning
❑ Amblyopia ❑ Watery Eyes
❑ Crossed Eye/Eye turn ❑ Itchy Eyes
❑ Eye Infections ❑ Gritty feeling of eyes
❑ Cataracts ❑ Dry Eyes
❑ Glaucoma ❑ Eye Injury
❑ Eye Strain/Headaches ❑ Iritis/Uveitis
❑ Corneal Abrasion ❑ Flashes of Light
❑ Macular Degeneration ❑ Floaters/Spots in Vision
❑ Retinal Detachment ❑ Sunlight Sensitivity
❑ Trouble Seeing at Night ❑ Double Vision
❑ Other Eye Disorders/Symptoms__________________

List any Eye Surgeries:_________________________

Contact Lenses

Do you want to wear contact lenses? ❑ Yes ❑ No
Have you ever tried contact lenses? ❑ Yes ❑ No
Do you currently wear contact lenses? ❑ Yes ❑ No
What kind?____________________________________
Solutions used_________________________________

Are you satisfied with the vision and comfort of your contact lenses? ❑ Yes ❑ No
Would you prefer clear contact lenses or colored contact lenses? ❑ Clear ❑ Colored
If you wear bifocals in your glasses, are you interested in 'bifocal' contacts? ❑ Yes ❑ No

The information in this confidential case history form is critical to the evaluation of your vision and health.

Patient Medical History

Name of Family Physician (if known)________________
Town____
Date of Last Physical Check-up_____________________

CURRENT MEDICATIONS (Rx or Over the Counter)
(List name of medications including eye drops, vitamins, & birth control pills)__________________________________
____
____

Allergies to medications? ❑ Yes ❑ No
If so, what medications?____________________________
____

Seasonal/environmental allergies? ❑ Yes ❑ No

Have you had ANY surgeries? ❑ Yes ❑ No
Type of surgeries & date _________________________
____
____

Have you ever been diagnosed or treated for the following health problems?

	Yes	No
Asthma	❑	❑
Arthritis	❑	❑
High Blood Pressure	❑	❑
Cholesterol	❑	❑
Blood Disorders/Anemia	❑	❑
Bronchitis/Respiratory	❑	❑
Sinus	❑	❑
Throat Infections	❑	❑
Thyroid - **hyper or hypo**	❑	❑
Cancer - **type** ___________	❑	❑
Diabetes - **type I or II**	❑	❑
Digestive Problems	❑	❑
Endocrine	❑	❑
Fatigue	❑	❑
Chronic Fevers	❑	❑
Genital/Urinary	❑	❑
Skin(Eczema/Psoriasis/other)	❑	❑
Kidney	❑	❑
Muscle/Bone	❑	❑
Neurological	❑	❑
Psychological	❑	❑
Unusual weight losses/gains	❑	❑
Currently Pregnant	❑	❑
Currently Breastfeeding	❑	❑

Others____
____

Social History

Do you use cigarettes/tobacco ❑ Yes ❑ No
How many per day? ______

Do you drink alcohol? ❑ Yes ❑ No
❑ Social only ❑ 1-2 daily ❑ More than 2 daily

Do you use other addictive substances? ❑ Yes ❑ No
Type?___________________________________

Family Medical/Eye History

Is there a family medical history of any of the following? ❑ No ❑ Yes (Please check boxes)

	Relationship (Mother, Father, etc….)
Blindness	❑ ______________________
Cataracts	❑ ______________________
Corneal Problems	❑ ______________________
Glaucoma	❑ ______________________
Eye Turn/Amblyopia	❑ ______________________
Macular Degeneration	❑ ______________________
Retinal Problems	❑ ______________________
Diabetes	❑ ______________________
Heart Disease	❑ ______________________
High Blood Pressure	❑ ______________________
Cancer	❑ ______________________
Others	❑ ______________________

I have read, I understand and I agree to the Financial Policy of Signature Eye Center (last revised 03/12/09).
Signature___________________________________

I have read, I understand and I agree to the Notice of Privacy Practices of Signature Eye Center (last revised 11/9/08)
Signature___________________________________

Dr. Koehler feels that the best way to examine your peripheral retina is with the **opto**map® Retinal Exam. Please read the **opto**map® information pamphlet for more details on this procedure. There is a discounted fee of $45 for this procedure, which is not covered by your insurance for screening a healthy retina. Dilation will be done if optomap is not performed, at no additional charge.

I have read, I understand and I agree to the **opto**map® Retinal Exam.
Signature___________________________________

Please keep a copy of any paperwork you would like:

- ❑ Financial Policy
- ❑ Notice of Privacy Practices
- ❑ **Opto**map® Retinal Exam Pamphlet