# 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.)
_________________________________________
_________________________________________

## 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:_______________________**

## 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?

## 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