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
❑ Amblyopia
❑ Crossed Eye/Eye turn
❑ Eye Infections
❑ Cataracts
❑ Glaucoma
❑ Eye Strain/Headaches
❑ Corneal Abrasion
❑ Macular Degeneration
❑ Retinal Detachment
❑ Trouble Seeing at Night
❑ Burning
❑ Watery Eyes
❑ Itchy Eyes
❑ Gritty feeling of eyes
❑ Dry Eyes
❑ Eye Injury
❑ Iritis/Uveitis
❑ Flashes of Light
❑ Floaters/Spots in Vision
❑ Sunlight Sensitivity
❑ 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	❑	❑
Autoimmune Disorder	❑	❑
High Blood Pressure	❑	❑
Cholesterol	❑	❑
Cardiac/Heart	❑	❑
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 ❑ Unknown

	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