Like us on: facebook

___DIABETES___DIABETIC RETIN___HYPERTENSION___NONE

Name_____ **Date of Birth**_____ **Age** _____ **Today's Date**_____

Home Address _____ **Town** _____ **State** _____ **Zip** _____

Home Phone _____ **Cell Phone** _____ **Email** _____

Reference_____ **Place of Employment** _____ **Phone** _____

Insurance Company_____ **Policy #**_____ **Social Security** _____-_____-_____

RX 1 O.D. _____ 20/ Add _____
PD ____ O.S. _____ 20/ Add _____

RX 2 O.D. _____ 20/ Add _____
PD ____ O.S. _____ 20/ Add _____

CC.

Uncorrected VA

	Distance	Near
O.D. 20/	_____	_____
O.S. 20/	_____	_____
O.V.20/	_____	_____

Present CL: 20/ CL V 20/

History

L.E.E. _____
DR. _____ _____ALL
LPE _____
MEDS _____
M. COND. _____
DM _____
FEH _____
EH _____
VIS.D. _____
VIS.N._____

Contact Lens History

TYPE_____
#YEARS WORN _____
AGE PR. CL _____
AVG. WT. _____
COMFORT _____
VIS.D. _____ ____Lubr. gtt
VIS.N._____
DAILY CL _____
SALINE _____
DISINF. SOAK _____
ENZYME _____

Refraction

K's O.D. _____c
O.S. _____c

Static O.D. _____20/
O.S. _____20/

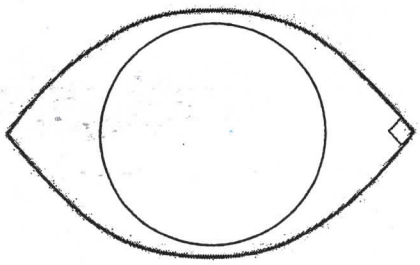
Subjective O.D. _____20/
O.S. _____20/

NRA
PRA

Time _____ T < DCT _____ Pupils _____ EOMS _____ CV _____
BP _____ ------c NCT _____ NPC _____ CF _____ ST _____

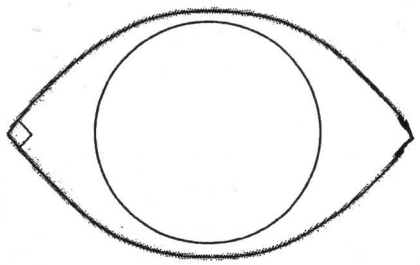
R

Conj. _____
Sclera _____
Cornea _____
Angle _____
Lens _____
Lids _____
Lashes _____
GPC _____



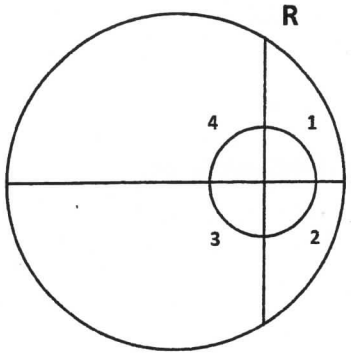
L

Conj. _____
Sclera _____
Cornea _____
Angle _____
Lens _____
Lids _____
Lashes _____
GPC _____



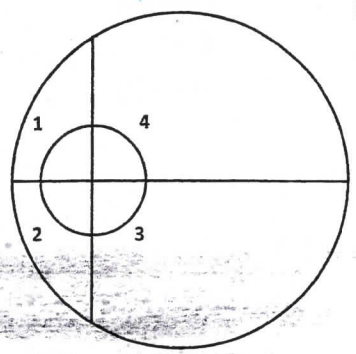
R

Media _____
C/D _____
A/V _____
Fundus
1 _____
2 _____
3 _____
4 _____
Macula _____



L

Media _____
C/D _____
A/V_____
Fundus
1 _____
2 _____
3 _____
4 _____
Macula _____



Patient Name_____ Reason for Visit _____

Occupation/Hobbies_____ Eye Injury/Surgery History_____

List Medications Taken_____

☐ Allergies ☐ Allergies to Medication List_____

Patient History	Yes
Eye Pain	☐
Blurred Vision	☐
Redness	☐
Light Sensitivity	☐
Burning/Tearing	☐
Lupus	☐
Arthritis	☐
Diabetes	☐
Hypertension (High Blood Pres)	☐
Thyroid Disorder	☐
Asthma/Breathing Problems	☐
Alcohol/Drug Use	☐
Sexually Transmitted Disease	☐
Glaucoma	☐

Family History	Yes	Relation to Patient
Glaucoma	☐	
Diabetes	☐	
Eye Surgery	☐	
Macular Degeneration	☐	
Eyeglass Wearers	☐	
Retinal Problems	☐	
Other	☐	
Other	☐	

Do you wear glasses? ☐ Yes ☐ No

If yes, Do you wear them for

☐ Distance ☐ Reading ☐ All the time

Do you wear contact lenses? ☐ Yes ☐ No

How old are your contacts that you are currently wearing? _____

Years of contact lens use:_____

Are they comfortable: Yes No

Cleaning solution_____

Type of Contacts_____

Time of day you put your lenses in_____

Time of day you take your lenses out_____

Approximate # of hours worn/day_____

A yearly exam and contact lens fitting is required for all contact lens patients

Person Responsible for Payment:

Name_____ Relation to patient_____

Address_____Town_____ State_____Zip_____

Home Phone_____Social Security #_____DOB_____

Place of Employment_____Business Phone_____

Address_____Town_____State_____Zip_____

Secondary Insurance_____ID#_____Policy Holder_____

AUTHORIZATION

I have reviewed the above information, and it is accurate to the best of my knowledge. I understand it will be used by the doctor to help determine appropriate and healthful eye care. I authorize release of all necessary information to secure payment by my insurance company. I understand Accu-Vision Center is not responsible for false information given by my insurance company regarding benefits and eligibility, and that I am ultimately responsible for all charges whether or not covered by my insurance.

ACKNOWLEDGEMENT OF RECEIPT I acknowledge that I receive a copy of Accu-Vision's Notice of Privacy Practices. I may read in office, request an electronic copy, a paper copy or refuse to read. If Accu-Vision changes it's Notice of Privacy Practices I will receive a copy of the new one at the time of my next visit. A copy will be in the office waiting area at all times.

CIRCLE ONE: Read in office Keep a copy Refuse to read

Signature_____Relation to patient_____Date_____