



# MACADAM VISION

WELCOME TO OUR OFFICE

Dedicated to your vision for life

## PATIENT INFORMATION

Today's Date \_\_\_\_\_

Name \_\_\_\_\_  
(Last, First, Middle Initial)

Mr. \_\_\_ Mrs. \_\_\_ Ms. \_\_\_ Miss. \_\_\_ Other \_\_\_\_\_

Gender: Male \_\_\_ Female \_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Phone Number(\_\_\_\_) \_\_\_\_\_ Home

(\_\_\_\_) \_\_\_\_\_ Work

(\_\_\_\_) \_\_\_\_\_ Cell

E-Mail Address \_\_\_\_\_

Birth Date \_\_\_\_\_  
Month Day Year

Drivers License Number \_\_\_\_\_ State \_\_\_\_\_

*If paying by check*

## NEW PATIENTS ONLY:

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
- Signage                 Yellow Pages
- Web Page: Which web page? \_\_\_\_\_
- Other \_\_\_\_\_

## INSURANCE INFORMATION

Vision Insurance Co. \_\_\_\_\_

Subscriber Name \_\_\_\_\_

Subscriber Ins. ID# \_\_\_\_\_

VSP Patients- last 4 digits of SSN: \_\_\_\_\_

Subscriber Birth Date \_\_\_\_\_

**Primary Medical Insurance** \_\_\_\_\_

Subscriber Name \_\_\_\_\_

Subscriber Ins. ID# or SSN: \_\_\_\_\_

Subscriber Birth Date \_\_\_\_\_

Person responsible for account:  Self

Other \_\_\_\_\_

(Last, First, Middle Initial)

(Address)

(City/State/Zip)

(Phone Number)

Mother \_\_\_\_\_ Father \_\_\_\_\_ Guardian \_\_\_\_\_

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

Do you participate in a flex spending account?

- Yes       No

*Please be advised if you are using insurance coverage for today's visit, this is a contract between you and your insurance company. You are responsible for any balance your insurance does not pay.*

*Payment for services and materials are due at time of service. Balances overdue more than 30 days will be charged \$5.00 each monthly billing cycle. Outstanding balances over 60 days will be sent to a collections agency.*

Dr. Initials \_\_\_\_\_

## LIFESTYLE QUESTIONS

**Do you.....(check box if your answer is yes)**

- ..have an east / west commute?
- ..work at a computer?
- ..spend time outdoors? How much? \_\_\_Hrs/week
- ..want information on Laser Vision Correction surgery?
- ..have interest in pharmaceutical grade supplements for eye health?
- ..have children?
- ..have family members in need of eye care?  
.....
- ..have prescription sunwear?
- ..have more than 1 pair of current Rx eyewear?

What is the major purpose of this visit?  
\_\_\_\_\_

Any problems with your current contact lenses or glasses?  
\_\_\_\_\_

Hobbies or Sports \_\_\_\_\_

Are you diabetic? Y / N Type I, Type II (non-insulin dependent)

Do you suffer allergies? Y / N Allergic to: \_\_\_\_\_  
\_\_\_\_\_

Medication Allergies? Y / N What happens: \_\_\_\_\_  
\_\_\_\_\_

Do you get headaches? Y / N migraines tension cluster  
mild Rate Severity: annoyance 1 2 3 4 debilitating agony

Have you had any operations? Y/N What kind: \_\_\_\_\_  
\_\_\_\_\_

Do you use tobacco? Y / N Alcohol? Y / N  
Other substance? \_\_\_\_\_

Name of Family Doctor \_\_\_\_\_

Date of last visit: \_\_\_\_\_ Date of last tetanus shot: \_\_\_\_\_

## Personal Eye Health History

- |                                      | Yes                      | No                       |
|--------------------------------------|--------------------------|--------------------------|
| Have you had any eye surgeries?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had any eye injuries?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have.....glaucoma?            | <input type="checkbox"/> | <input type="checkbox"/> |
| cataracts?                           | <input type="checkbox"/> | <input type="checkbox"/> |
| dry eyes?                            | <input type="checkbox"/> | <input type="checkbox"/> |
| blurred vision?                      | <input type="checkbox"/> | <input type="checkbox"/> |
| other eye problems?                  | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you wear glasses?                 | <input type="checkbox"/> | <input type="checkbox"/> |

Date of Last Eye Exam \_\_\_\_\_ By Whom? \_\_\_\_\_

Were your eyes dilated?  ..Yes  ..No  ..Can't remember

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

## FAMILY MEDICAL/EYE HISTORY

(Check all that apply)

Is there a family medical history of any of the following:  
Relationship (Mother's or Father's side)

- Blindness  \_\_\_\_\_
- Cataracts  \_\_\_\_\_
- Corneal Problems  \_\_\_\_\_
- Diabetes  \_\_\_\_\_
- Glaucoma  \_\_\_\_\_
- Heart Disease  \_\_\_\_\_
- High Blood Pressure  \_\_\_\_\_
- High Cholesterol  \_\_\_\_\_
- Macular Degeneration  \_\_\_\_\_
- Retinal Problems  \_\_\_\_\_
- Other  \_\_\_\_\_

## PATIENT MEDICAL HISTORY

Current Medications (Rx or Over the Counter) List name of medications including eye drops, vitamins, and birth control pills \_\_\_\_\_  
\_\_\_\_\_

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

	Yes	No
Allergies/Immune	<input type="checkbox"/>	<input type="checkbox"/>
Blood/Lymph	<input type="checkbox"/>	<input type="checkbox"/>
Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Gastrointestinal	<input type="checkbox"/>	<input type="checkbox"/>
Ears/Nose/Throat	<input type="checkbox"/>	<input type="checkbox"/>
Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure/Cardio	<input type="checkbox"/>	<input type="checkbox"/>
Muscle/Bone	<input type="checkbox"/>	<input type="checkbox"/>
Neurological	<input type="checkbox"/>	<input type="checkbox"/>
Psychological	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>
Sinus	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid/Endocrine	<input type="checkbox"/>	<input type="checkbox"/>
Skin	<input type="checkbox"/>	<input type="checkbox"/>

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

We are dedicated to improving our patients' quality of life by providing a clinical experience that invokes a sense of caring expertise memorable to the point of enthusiastic comment.

Dr. Initials \_\_\_\_\_