

Macadam Vision Clinic welcomes you to our office!

As a new patient to our practice, we would like to offer a warm welcome and our thanks for choosing us to provide your eye health and vision care. In order for us to establish your file, and provide the most beneficial use of your time with us, the doctor has asked you to complete the following tasks and bring the results to your appointment. The doctor needs this in order to give you the best care possible.

Completed Welcome to the Office Form: This diagnostic information includes personal and family information needed to establish your file, as well as your current eye health and vision status. Your responses will guide our doctors and staff, and remind us to address any significant issues during your visit.

Completed Medical and Eye Health History: Since many general health conditions may be associated with visual symptoms and/or eye health problems, this important record (now required by state health boards and virtually any medical and optical insurance plans) will allow us to care for you as a “whole person” rather than just a pair of eyes. This form includes a complete list of prescription and non-prescription medication, which may be brought in as a separate list for us to photocopy if you prefer.

Completed Digital Retinal Photography Form: You may choose from one of two retinal health evaluation options.

Insurance cards or claim forms: For any optical and/or medical insurance for which you may be covered. (Even for “routine” visits, if a medical eye condition is discovered during your examination we can submit a claim to your health insurance for the medical evaluation portion of your examination).

If you were informed that we are not a provider of your vision benefits coverage, please call the number on the back of your insurance card and get answers to the following questions.

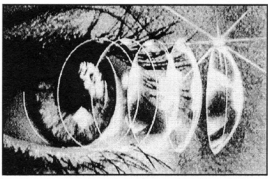
If we do not have this information, you will be responsible for paying us for all charges at the time of service and then seeking reimbursement from your coverage:

- Do I have “out of network” vision exam coverage?
- Do I have eyeglasses or contact lens materials coverage?
- Do I have medical coverage?
- Do I have a co-payment?
- Are my family members covered?
- Do I need to satisfy a deductible?

Eyeglasses: Please bring ALL pairs of eyeglasses you currently use, including prescription or non-prescription reading glasses, sunglasses, etc. We have instruments to compare the optical power of your old lenses with your new exam findings, thus enabling us to determine and explain how your vision has changed over time. We can also evaluate the condition and fit of your current eyewear.

Contact Lenses: It is best to wear your current contacts to your appointment if possible. Next best is to bring them along in your case. If you wear planned replacement or disposable lenses, it is very helpful if you bring along your cartons or lens packets that indicate the lens series, power, manufacturer, etc.

Completing the task list for the items that apply to you will assure you of receiving the most thorough and professional care possible and in a very efficient manner. We look forward to your visit!



MACADAM VISION

WELCOME TO OUR OFFICE

Dedicated to your vision for life

PATIENT INFORMATION

Today's Date _____

Name _____
(Last, First, Middle Initial)

Nickname _____

Gender: Male _____ Female _____

Mr. _____ Mrs. _____ Ms. _____ Miss. _____ Other _____

Birthdate _____ / _____ / _____

Occupation _____

Employer _____

Communication Info: Please Circle Preference
Cell, Home, Work, Email, US Mail

Home () _____ - _____

Work () _____ - _____

Cell () _____ - _____

Email _____

Street _____

City _____

State _____ Zip _____

The new Health Care Act requires we ask the following questions to be in accordance with "Meaningful Use" of Electronic Health Records. Meaningful Use: An incentive to improve the health of the nation by ensuring that patients receive well-coordinated care within and across all healthcare organizations, settings, and levels of care.

(You may enter "Decline to provide")

SSN _____

Marital Status _____

Primary Language _____

Special Needs _____

Race _____

Ethnicity (Hispanic/Latino) YES / NO

Mother's Maiden Name _____

Birth State _____

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?

Yellow Pages Insurance List

Signage

Internet: Insurance List

Our Website

Yellow Pages

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 _____

Do you participate in a flex spending account?

Yes

No

Dr. Initials _____

LIFESTYLE QUESTIONS

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

- ..work at a computer?
- ..spend time outdoors? How much? ___Hrs/week
- ..have prescription sunwear?
- ..want information on Laser Vision Correction surgery?
- ..have interest in pharmaceutical grade supplements for eye health?
- ..have more than 1 pair of current Rx eyewear?
- ..have family members in need of eye care?
- ..have children?
- ..headaches...Mild? Moderate? Severe?

What is the major purpose of this visit?

Any problems with your current contact lenses or glasses?

Do you suffer allergies? Y / N Allergic to: _____

Medical Allergies? Y / N What happens? _____

SOCIAL HISTORY

Drug Abuse: Yes _____ No _____
If Yes: Name of drug _____

Alcohol Use: Yes _____ No _____
If Yes: # of drinks per week _____

Tobacco Use: Yes _____ No _____
If Yes:
Smoked for _____ years
Packs per day _____

Hobbies _____

Name of Family Doctor _____

Date of last visit: _____ Date of last tetanus shot: _____

FAMILY MEDICAL/EYE HISTORY

<p><u>I have been</u> diagnosed with: (check those that apply)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Glaucoma <input type="checkbox"/> Cataracts <input type="checkbox"/> Macular Degen <input type="checkbox"/> Eye Injury <input type="checkbox"/> Retinal Disease <input type="checkbox"/> Other Diseases <input type="checkbox"/> Blindness <input type="checkbox"/> Strabismus <input type="checkbox"/> Amblyopia <input type="checkbox"/> Diabetes <input type="checkbox"/> Dry Eye <input type="checkbox"/> Other <input type="checkbox"/> Other 	<p>Do you have a family history of: (Please list the relationship of the family member to you)</p> <ul style="list-style-type: none"> <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____
--	---

PATIENT MEDICAL HISTORY

Please list all medications that you are taking:
(include eye drops, birth control, supplements)

Would you consider your overall health good? Y / N

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

	Yes	No
Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/>
Ear,Nose,Mouth,Throat	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>
Gastrointestinal	<input type="checkbox"/>	<input type="checkbox"/>
Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>
Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>
Integumentary (skin)	<input type="checkbox"/>	<input type="checkbox"/>
Neurological	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine	<input type="checkbox"/>	<input type="checkbox"/>
Hematologic/Lymphatic	<input type="checkbox"/>	<input type="checkbox"/>
Allergy/Immune	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>

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

Surgical History Procedures and Dates: _____

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..... blurred vision? 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? <input type="checkbox"/> ..Yes <input type="checkbox"/> ..No <input type="checkbox"/> ..Can't remember		
Have you ever tried contact lenses? <input type="checkbox"/> ..Yes <input type="checkbox"/> ..No		
Do you currently wear contact lenses? <input type="checkbox"/> ..Yes <input type="checkbox"/> ..No		
What kind? _____ Solutions used _____		
Are you satisfied with the vision and comfort of your contact lenses? <input type="checkbox"/> ..Yes <input type="checkbox"/> ..No		

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 _____