DATE: ____________________ **Welcome to our office!**

***The highlighted areas are key to uncovering symptoms of Digital Eye Strain (DES) ***

NAME: __________________________________ AGE:_______ BIRTH DATE:

ADDRESS:____ HOME PHONE

CITY:__________________________ST:_______ZIP:___________ CELL PHONE

Occupation____ EMAIL: ___________________________

INSURANCE INFORMATION ✈VSP ✈Eye Med

Vision Insurance Company________________________ Relationship to Insured ____________________
Name of Insured_____________________________ Insured's Birth Date ____________________
Insured's Employer____________________________ Last 4 of SS number ____________________

How did you hear about (Name of Your Practice)? ___________________________ Previous Patient? Yes No

Reason for today's visit: ✈ Emergency ✈ Vision Exam ✈ Vision Exam and Contact Lenses

Medications you are taking: ____

List allergies to medications: ____

Check all that apply to your relatives: (parents, grandparents, siblings, etc.)
✈Diabetes ✈Glaucoma ✈Cataracts ✈Macular Degeneration
✈Other:____

Please check all that apply to YOU:

✈Blurred Vision	✈Fluctuation in vision	✈Tired eyes	✈Headaches	✈Body fatigue
✈Dry eyes	✈Light sensitivity	✈Eye rubbing	✈Poor night vision	✈Reduced concentration
✈"Lazy" eye	✈Had LASIK	✈Itchy eyes	✈Flashes/Floaters	✈Double vision
✈Diabetes	✈High blood pressure	✈Thyroid	✈High cholesterol	✈Pregnant

✈Other:____

Do you use a Smartphone?______ If yes, how many hours a day do view the screen?__________________

Do you use a Computer or Tablet?______ If yes, how many hours a day on each device?_________________________

Do you like to read books?______ If yes, how many hours a day do you read books?___________________

Do you alternate your vision between two distances?

TV & Smartphone________ hrs/day TV & Tablet________ hrs/day TV & Computer_______ hrs/day

Computer & Reading Material (paper)________ hrs/day

HOBBIES?____

Are you a gamer? ____ If yes, how many hours per day do you spend gaming? ___
How many hours do you game on each device? ___ Console/TV ___Tablet ___ Smart Phone ___ Gaming Specific device e.g. DS

Would you like your new glasses to be (check all that apply): UV protective ___ Easy to Clean ___ Durable ___ Reflection Free ___

If you are getting contact lenses today, please answer the following (or check the one that applies)
✈ First time wearer ✈ Previous wearer what type of lenses do you wear? ✈Hard (gas perm) ✈Soft

Dilation makes your pupils large so that the doctor can get a better view of the internal eye. It allows for a more thorough eye-health examination. The drops take about ten minutes to take effect and may cause blurry vision at near with increased light sensitivity for 3-5 hours. If you are diabetic, have high blood pressure, are very near sighted, or have not had your eyes dilated in the past 2-3 years, we strongly recommend dilation. **Do you wish to have your eyes dilated?**
✈Yes ✈No

Authorization
I certify that I have read and understand the above information to the best of my knowledge. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits.

HIPPA acknowledgement:
Our Privacy Practice is not to release any of your information without your written consent.
(A copy of Notice of Privacy Practices is available upon request).

Date:____________ Signature:_____________________________ Parent Name_____________________________