# Welcome To Our Office

*The mission of the Vision Clinic is to provide individual comprehensive medical and vision eye care in a friendly, caring environment. Our staff will strive to offer our valued patients personalized services and products that meet their highest expectations.*

**Today's Date:**_____

## Patient Information

Last:_____

First:_____ M.I.:____

Mailing Address:_____

City:_____ State:_____

Zip:_____ Sex: Male Female

Primary Phone:_____

Secondary Phone: _____

Email: _____

Date of Birth:_____Age: _____

Patient's SSN: _____

Employer/ School: _____

Occupation/Grade:_____

Spouse/Parent Name: _____

Spouse/Parent Work: _____

What is the reason for your visit?

_____

_____

Any problems with your current glasses &/or contacts?

_____

**NEW PATIENTS ONLY–VERY IMPORTANT!**

Who may we thank for referring you to our office?

_____

## Insurance Information

Vision Insurance:_____

Primary Subscriber Name:_____

Subscriber SSN: _____

Subscriber Date of Birth: _____

Medical Insurance:_____

Primary Subscriber Name:_____

Subscriber SSN: _____

Subscriber Date of Birth: _____

## Lifestyle Information

**Please check all that apply to you**

- ☐ Work on a screen? _____ hrs/day
- ☐ Considering thinner, lighter lenses for glasses?
- ☐ Have more than one pair of prescription glasses?
- ☐ Own prescription sunglasses?
- ☐ Spend time outdoors? _____hrs/day?
- ☐ Prefer to not wear your glasses at times?
- ☐ Interested in trying the latest contact lenses?
- ☐ Interested in getting information on Laser Vision Correction Surgery?
- ☐ Have children and/or family members in need of eyecare?

**Have you experienced, been diagnosed, or treated for any of the following issues?**

- ☐ Blurry vision
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Retinal Detachment
- ☐ Flash of Light
- ☐ Floaters/Spots
- ☐ Iritis/Uveitis
- ☐ Eye Infections
- ☐ Corneal Abrasions
- ☐ Burning/Itchiness/Grittiness or Occasional Dryness
- ☐ Watering/Tearing
- ☐ Crossed Eye/Eye turn or Lazy Eye
- ☐ Eye Injury
- ☐ Double Vision
- ☐ Sunlight/Bright Light Sensitivity
- ☐ Trouble seeing at night
- ☐ Uncomfortable Glasses

## Patient Medical History

Primary Physician: _____

Clinic Name: _____

Date of last physical check-up: _____

**Current Medications (Rx or Over the Counter)**

Please list names of medicines and dosages if known.
(including eye drops, supplements, & birth control)

_____

_____

_____

_____

_____

Any known medication allergies? ____ Yes ____ No

If yes, list medication allergies:

_____

_____

Do you use any cigarettes/tobacco/vaping, alcohol, or other substances? ____ Yes ____ No

Have you had any Eye Surgeries? ____ Yes ____ No

__ Cataract __ LASIK __ Retinal __ Corneal __ Other

**Do you have/had a diagnosis or treatment for the following health problems?**

**Please check all that apply & add notes if needed.**

- ☐ Allergies_____
- ☐ Arthritis_____
- ☐ Blood/Lymph_____
- ☐ Cardiac (heart)_____
- ☐ Cancer_____
- ☐ Cholesterol_____
- ☐ Diabetes/Endocrine_____
- ☐ Digestive_____
- ☐ Ears/Nose/Throat(Sinus, Throat Infections)_____
- ☐ Fatigue_____
- ☐ Fevers_____
- ☐ Genitourinary_____
- ☐ High Blood Pressure_____
- ☐ Integumentary(Skin, Eczema, Rashes)_____
- ☐ Kidney_____
- ☐ Muscle/Bone_____
- ☐ Neurological_____
- ☐ Psychological_____
- ☐ Respiratory(Bronchitis/Pneumonia)_____
- ☐ Thyroid_____
- ☐ Unusual weight changes_____

## Patient Eye Health & Vision History

Date of Last Eye Exam: _____

By whom & where? _____

**Contact Lenses**

Are you interested in trying 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

**Glasses**

If you wear Bifocals, do the lines or head tilting bother you? ___ Yes ___ No

## Family Eye & Medical History

**Is there a family medical history of any of the following:**

**Please check all that apply and note relationship**

- ☐ Blindness_____
- ☐ Cataracts_____
- ☐ Corneal Problems_____
- ☐ Glaucoma_____
- ☐ Lazy Eye _____
- ☐ Macular Degeneration _____
- ☐ Retinal Problems _____
- ☐ Heart Disease_____
- ☐ Diabetes _____

## Please read and sign

I authorize and request my insurance company to pay directly to the eye doctor any insurance benefits otherwise payable to me. I understand that my eye care insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my or my dependents behalf. If my insurance company has not reimbursed this office in full within 90 days I will be billed directly.

I authorize the release of any information including the diagnosis and records of any treatment or examination, rendered to me or my dependent during the period of such eye care, to third party payers and/or health practitioners. I certify that I have read and understand the above information and Privacy Policy of the Vision Clinic. (available at kalispellvisionclinic.com)

**Signature:** _____ **Date:** _____