TOTAL VISION
Family Eye Care
Your eyes are special, Your eyecare should be too

PATIENT REGISTRATION & MEDICAL HISTORY FORM

First Name: _____ Last Name: _____ Middle Initial: _____ Preferred Name: _____

Birth Date: _____ Social Security Number: _____ Gender: M / F Insured's Name: _____

Home Address: _____ Zip: _____ City: _____ State: _____

Which phone number would you prefer we use to contact you? ☐ **Home** ☐ **Work** ☐ **Cell** Home Phone: _____ Work Phone: _____

Cell Phone: _____ Emergency contact: _____ **E-mail address**: _____

Marital Status: ☐ **Single** ☐ **Married** ☐ **Other** Referred by: _____ ***We must have a copy of all insurance cards on the day of service***

Primary Medical Insurance: _____ Secondary Medical Insurance: _____

Vision Insurance: _____ Insured Social Security Number: _____

Insured's Birth Date:_____ Insured's Employer: _____

Family Doctor: _____ Family Dr. Clinic/Phone: _____

Family Members: _____For ease of data transfer, are they patients at this office? **Y / N**

NOTICE OF PRIVACY PRACTICES: I/We have been offered a copy of Total Vision Family Eye Care statement on privacy practices
AUTHORIZATION TO RELEASE INFORMATION: I/We hereby authorize Total Vision Family Eye Care to release any medical or incidental information that may be necessary for medical benefit of in processing applications for financial benefit. This includes but is not limited to my insurance company, Rehabilitation Services, Social Security Administration, and Worker's Compensation.
CONSENT FOR TREATMENT: I/We hereby authorize Total Vision Family Eye Care to administer diagnostic and medical procedures as may be necessary for proper health care.
OFFICE POLICY ON PAYMENT: I understand that I am responsible for payment of all charges. As a courtesy, my insurance will be billed for me. It is my responsibility to pay any deductible, copay or any other balance not paid by my insurance company. I authorize insurance benefits to be paid directly to the provider.
VISION PLAN COVERAGE: I/We understand that only one vision plan may be used for exam/materials per visit-per patient and that the vision plan to be used must be chosen before the exam occurs and can not change at a later date. If I do not supply my vision plan at the time of services I will be required to pay up front and self-submit on my own.

SIGNATURE: _____ DATE: _____

CHIEF COMPLAINT

How can we help you today? In this space please check/explain any signs and/or symptoms you are experiencing. Medical insurance will only cover if there is a medical reason for the exam/test such as loss of vision, headaches, eye pain, eye itching or burning, redness, glaucoma, cataracts, floaters, dry eyes, etc.

☐ **Loss of vision**	☐ **Floaters**	☐ **Eye pain/soreness**	☐ **Glare**	☐ **Dry eyes**
☐ **Blurred vision**	☐ **Crossed eyes**	☐ **Watery eyes**	☐ **Light sensitivity**	☐ **Red eyes**
☐ **Double vision**	☐ **Flashes of light**	☐ **Sandy/gritty feeling**	☐ **Tired eyes**	☐ **Burning/itching**

Other (explain):

HISTORY OF PRESENT ILLNESS

Location *Which eye has the problem?* ☐ **Right** ☐ **Left** ☐ **Both**
Quality *How is it affecting you?* ☐ **Bothersome** ☐ **Aware** ☐ **Painful**
Severity *How severe is the problem?* ☐ **Mild** ☐ **Moderate** ☐ **Severe**
Duration *How long have you had the problem?* _____

Timing *Is it new, ongoing, returning?* ☐ **New** ☐ **Ongoing** ☐ **Returning**
Context *Associated w/:* ☐ **Infection** ☐ **Medical condition** ☐ **Injury** ☐ **Surgery**
Modifiers *Previous treatment?* ☐ **Drops** ☐ **Medication** ☐ **Other:** _____
Symptoms *Are there associated symptoms?* ☐ **Headache** ☐ **Other:** _____

FAMILY HISTORY

Has anyone in your family been diagnosed with any of the following (check all that apply):
☐ **No problems** ☐ **Diabetes** ☐ **High blood pressure** ☐ **Cancer**

Has anyone in your family been diagnosed with any of the following eye problems (check all that apply):
☐ **No problems** ☐ **Glaucoma** ☐ **Amblyopia** ☐ **Cataracts** ☐ **Macular degeneration** ☐ **Strabismus (eye turn)**

LIFESTYLE SURVEY

Are your eyes sensitive to sunlight?
□ Y □ N

Problems with reflections and/or glare?
□ Y □ N

Please circle all activities/hobbies that apply to you:
outdoor sports: _____
Gardening
Gaming/Computers
Music/Art
Other:_____

Do you work at a computer ?
□ Y □ N IF so, how long per day _____

Want information on thinner / lighter lenses?
□ Y □ N

What is your occupation? _____

CURRENT VISION

Glasses: Do you currently wear glasses? □ **Y** □ **N** *if yes, answer the questions below; if no, continue to contact lenses section:*
What type of lenses is in your glasses? □ **Single vision** □ **Bifocal** □ **Trifocal** □ **No-line (Progressive)**

Contact Lenses: Do you currently wear contact lenses? □ **Y** □ **N** *if yes, answer the questions below; if no, continue to past ocular history section:*
What type of contact lenses do you wear? □ **Soft** □ **Rigid**
What is the manufacturer/model of your contact lenses? _____
What are the powers of your contact lenses (if you know)? _____
How old are your current contact lenses? _____ **Months / Years**
How often do you replace your contact lenses? □ **Daily** □ **Weekly** □ **2 weeks** □ **Monthly** □ **3 months** □ **6 months** □ **Annually**
What solutions do you use to care for contact lenses? □ **Renu** □ **Optifree** □ **Clear Care** □ **Biotrue** □ **Boston** □ **Optimum** □ **Other:** _____

REVIEW OF SYSTEMS

Ocular/Eye Problems
- Inflammatory disorder □ Y □ N
- Surgery □ Y □ N
- Glaucoma □ Y □ N
- Amblyopia (lazy eye) □ Y □ N
- Cataract □ Y □ N
- Retinal problems □ Y □ N
- Macular degeneration □ Y □ N
- Strabismus (eye turn) □ Y □ N
- Patching □ Y □ N
- Other _____

Constitutional Problems
- Cancer □ Y □ N
- Fatigue □ Y □ N
- Developmental disability □ Y □ N
- Other _____

Ears, Nose, Mouth, Throat Problems
- Laryngitis □ Y □ N
- Dry mouth □ Y □ N
- Hearing loss □ Y □ N
- Sinusitis □ Y □ N
- Other _____

Neurological Problems
- Cerebral palsy □ Y □ N
- Multiple sclerosis □ Y □ N
- Tumor □ Y □ N
- Epilepsy □ Y □ N
- Other _____

Psychiatric Problems
- Depression □ Y □ N
- Other _____

Cardiovascular Problems
- Vascular disease □ Y □ N
- Stroke □ Y □ N
- Congestive heart failure □ Y □ N
- Heart disease □ Y □ N
- High blood pressure □ Y □ N
- Other _____

Respiratory Problems
- Emphysema □ Y □ N
- Bronchitis □ Y □ N
- Smoker □ Y □ N
- COPD □ Y □ N
- Asthma □ Y □ N
- Other _____

Gastrointestinal Problems
- Colitis □ Y □ N
- Chron's disease □ Y □ N
- Ulcer □ Y □ N
- Other _____

Genitourinary Problems
- Prostate disease/cancer □ Y □ N
- STD □ Y □ N
- Kidney disease □ Y □ N
- Other _____

Musculoskelatal Problems
- Ankylosis spondylitis □ Y □ N
- Fibromyalgia □ Y □ N
- Muscular dystrophy □ Y □ N
- Osteoarthritis □ Y □ N
- Other _____

Skin Problems
- Rosacea □ Y □ N
- Psoriasis □ Y □ N
- Eczema □ Y □ N
- Other _____

Endocrine Problems
- Insulin dependent diabetes □ Y □ N
- Hormonal dysfunction □ Y □ N
- Thyroid dysfunction □ Y □ N
- Non-insulin diabetes □ Y □ N
- Other _____

Blood/Lymph Problems
- Large volume blood loss □ Y □ N
- Anemia □ Y □ N
- Other _____

Allergy/Immunologic Problems
- Environmental allergies □ Y □ N
- Rheumatoid arthritis □ Y □ N
- Drug allergies □ Y □ N
- Lupus □ Y □ N
- Other _____

Do you smoke? Y N

Do you consume alcohol? Y N

Do you sometimes experience dry eyes? □ Y □ N

Prefer not to wear your glasses at times? □ Y □ N

Interested in newer contact lens technology? □ Y □ N

Want information on LASIK vision surgery? □ Y □ N

Want a non-surgical option to LASIK? □ Y □ N

List any medications you are currently taking:

_____

_____

List any medicine allergies:

_____

List any other allergies:

_____

_____