WELCOME TO OUR OFFICE!!!

Date_____Patient's Name_____
Age_____Date of Birth_____Parent's Name (If minor)_____
Social Sec. Number_____Driver's License (if writing a check)_____
Mailing Address_____
Telephone (Home)_____(Cell)_____(Work)_____ext:_____
Best Time to Call?_____E-mail Address_____
Spouse's Name_____Responsible Party for Account_____
Do you have vision insurance?_____Yes_____No If yes, list insurance provider_____
Date of last eye exam_____ Did you get glasses at that time?_____ By Doctor_____

Do you currently wear glasses?_____If so, when were they prescribed?_____
Are you having any visual problems with them?_____
Are your current glasses: _____Single Vision_____Bifocals_____Progressives. Do you have distorted, double or loss of vision?_____
Do you have trouble with glare or night time driving?_____ Do you use a computer?_____ How many hours?_____
Have you ever had any eye surgery / Injuries? _____ Any vision training or eye exercises?_____
Are you interested in contact lenses today?_____ Have you worn contacts before? If yes, how long ago_____
What kind of contacts were prescribed: Gas Permeable_____ Soft_____ Daily Wear_____ Extended Wear_____ Disposable_____ Toric_____

Do you *routinely* experience any of the following with your eyes: (Circle all that apply)

Tearing	Pain	Headaches	Burning	Light Flashes/Floaters
Watery	Redness	Migraines	Itching	Light Sensitivity
Discharge	Irritation	Twitching	Dryness	Foreign Body Sensation

GENERAL HEALTH (PAST OR PRESENT) this applies to you: (check all that apply)

_____Glaucoma	_____Macular Degeneration	_____Cancer	_____Allergies
_____Cataracts	_____Crossed Eyes	_____High Cholesterol	_____Arthritis
_____Retinal Disease	_____Lazy Eye	_____High Blood Pressure	_____Asthma
_____Blindness	_____Drooping Eyelid	_____Heart Disease	_____Diabetes

Family Physician_____Address_____Phone number_____
Are you presently being treated for any medical conditions?_____
Last General health exam?_____Are you allergic to any medications? (If so, please list)_____
Please list any current medications (including hormones or birth control pills)_____
_____
Are you pregnant and/or nursing? _____ If so, how many months pregnant?_____

FAMILY HISTORY (Blood relatives who have):

_____Crossed Eyes	_____Blindness	_____Heart Disease	_____Eye Diseases
_____Macular Degeneration	_____Glaucoma	_____High Blood Pressure	_____Cancer
_____Retinal Detachment/Disease	_____Cataracts	_____High Cholesterol	_____Diabetes

Your Occupation?_____Your Hobbies?_____
_____
Do you swim, water ski, snowboard, snow ski, fish, boating? _____
Does the reflection / glare bother you from any of these activities?_____In daytime, night or both?_____

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

The above information is accurate and true to the best of my knowledge. I understand that I am responsible to pay for services rendered, including reasonable attorney's fees and costs of collection in the event of default. I further understand that if payment becomes sixty days past due, a finance charge of 1.5% per month (18% annually), will be added to the balance due.

SIGNATURE OF RESPONSIBLE PARTY_____**DATE:**_____

HIPPA COMPLIANCE ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy, (or was offered a copy) of Dr. Bryan Vanesian, O.D. notice of privacy practices.

Signature _____**Date:**_____