WELCOME TO OUR OFFICE!

PATIENT INFORMATION

❑ Mr. ❑ Dr. ❑ Mrs. ☐ ❑ Ms.	Last Name	First	Middle Initial

Address	Apt#	City	State	Zip

Birth date	Age	Social Security No.	Home Phone ( )	Cell: ( ) Work: ( )

❑ Male ❑ Female ☐	❑ Single ❑ Married ❑ Other	Spouse's name:	❑ Full Time ❑ Part Time ❑ Not employed	❑ Other ❑ Retired ❑ Student

Employer	Occupation	Email address

We thank our patients in a special way when they refer us new patients. Whom may we thank for sending you here?
Relative/Friend's Name: ________________________________
❑ Insurance ❑ Location

VISION INSURANCE

Vision Insurance Co.	Primary Subscriber	Relationship to primary subscriber: ❑ Self ❑ Spouse ❑ Child
Insurance ID#	Primary subscriber's Soc Sec No	Subscriber's Birth date

Secondary Vision Insurance (if applicable)

Vision Insurance Co.	Primary Subscriber	Relationship to primary subscriber: ❑ Self ❑ Spouse ❑ Child
Insurance ID#	Primary subscriber's Soc Sec No	Subscriber's Birth date

HEALTH INSURANCE

Health Insurance Co.	Primary Subscriber	Relationship to primary subscriber: ❑ Self ❑ Spouse ❑ Child
Insurance ID#	Primary subscriber's Soc Sec No	Subscriber's Birth date

I authorize the doctor to release any information including the diagnosis and the records of any treatment or examination rendered to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me. I understand that I am responsible for all services or materials whether or not covered by my insurance and that payment is due when services are rendered.

Signature____ Date________________________________

How long has it been since you last eye exam? ______years _______ months

Are you currently having any of the following vision problems? If Yes, please check box.

- ❑ Dry/gritty eyes
- ❑ Blurred vision
- ❑ Eye strain
- ❑ Double vision
- ❑ Frequent headaches
- ❑ Itchy or burning eyes
- ❑ Light sensitivity
- ❑ Twitchy eye lids
- ❑ Red/watery eyes
- ❑ Pain in the eyes
- ❑ Tiredness/sleepiness
- ❑ Other

Which of the following types of glasses or vision aids have you been prescribed?

- ❑ Clear prescription glasses
- ❑ Sun prescription glasses
- ❑ Computer prescription glasses
- ❑ Prescription sports goggles
- ❑ Safety glasses (___ w/rx)
- ❑ Contact lenses
- ❑ Non-prescription sunglasses
- ❑ Magnifying lenses or Loupes
- ❑ Microscopes/Telescopes

How much time do you spend on the computer? _____ hrs/day or ______hrs/wk
How much time do you spend watching TV? _____hrs/day
How many hours do you spend in the sun per day? ________

Regarding your primary prescription glasses, are they:

- ❑ Scratched, worn, or damaged
- ❑ Lost
- ❑ Doesn't fit well
- ❑ Uncomfortably heavy
- ❑ Out of style or no longer pleasing

When using the computer, do you use separate prescription computer glasses?

- ❑ Yes
- ❑ No, I use my regular prescription glasses
- ❑ No, I don't wear anything

What type of sunglasses are you currently using to protect your eyes from UV radiation from the sun?

- ❑ Prescription sunglasses
- ❑ Clip-ons
- ❑ Transition lenses
- ❑ Non-prescription sunglasses
- ❑ Polarized lenses

Do you have emergency spare pair of glasses should you lose or break your regular glasses?

- ❑ Yes, with an updated prescription
- ❑ No, I do not have emergency glasses
- ❑ Yes, but with an older prescription

Which of the following sun activities do you frequently engage in?

- ❑ Walking/jogging/hiking
- ❑ Gardening
- ❑ Traveling/sightseeing
- ❑ Driving/commuting
- ❑ Sports (Golf, Fishing, etc.)
- ❑ Other

MEDICAL & OCULAR HEALTH HISTORY

Primary Physician ______________________________ **City** _________________

Date of last visit ______________________________

Have you ever had eye surgery? If yes, when and why ____

Do you or your relatives have history of any of the following? If Yes, please check box.

SELF	RELATIVE	SELF	RELATIVE	SELF	RELATIVE	SELF	RELATIVE
☐	☐ Eye infections	☐	☐ Glaucoma	☐	☐ Dry Eyes Syndrome	☐	☐ Macular Degeneration
☐	☐ Eye allergies	☐	☐ Cataracts	☐	☐ Diabetic Retinopathy	☐	☐ Retinal Detachment
☐	☐ Eye injury	☐	☐ Strabismus	☐	☐ Temporary vision loss		

Do you or your relatives have any of the following diseases which may lead to vision problems?

SELF	RELATIVE	SELF	RELATIVE	SELF	RELATIVE
☐	☐ Diabetes	☐	☐ High blood pressure	☐	☐ Autoimmune: arthritis/Lupus/Crohn's
☐	☐ Joint/back problem	☐	☐ High cholesterol	☐	☐ Skin problems: cancer/eczema/sunburns
		☐	☐ Infectious: syphillus/herpes/HIV	☐	☐ Vascular diseases: stroke/heart attacks

Please check Yes or No

Do you smoke?	Yes ☐	No ☐	How much? ______________________________
Do you drink alcohol?	Yes ☐	No ☐	How much? ______________________________
Do you take medications?	Yes ☐	No ☐	Please list names and how often ____________________

____

Do you use other substances? Yes ☐ No ☐

CONTACT LENS HISTORY

Please complete this section if you have worn contact lenses in the past and want to continue wearing them.

What type of contact lenses do you have?

- ❑ One day soft disposable
- ❑ Monthly soft disposable
- ☐ Overnight Ortho K corrective lenses
- ❑ Biweekly soft disposable
- ❑ Quarterly soft disposable
- ❑ 6 months or more soft
- ❑ RGP (rigid gas permeable) lenses

How often do you wear your contact lenses? _______ **time/week at duration of** _______ **hrs/day**

Do you wear your contact lenses overnight?

- ❑ Yes, routinely
- ❑ Sometimes
- ❑ Never

Are you experiencing any of the following while using your contact lenses?

- ❑ Dryness towards the end of the day
- ❑ Irritation
- ❑ Blurriness
- ❑ Fluctuations in vision
- ❑ Redness
- ❑ Tears easily

What is the name of your cleaning/disinfection system? ____

Are you interested in laser vision correction or overnight Ortho-K correction lens? Yes ☐ No ☐

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received the Notice of Privacy Practices from Crystal Vision Optometry

Signature ______________________________________ Date ______________________________