



How did you hear about us? Friend/relative Insurance Ad Previous Patient Walking by New Patient

LAST NAME FIRST NAME

AGE DATE OF BIRTH

ADDRESS

CITY STATE ZIP CODE

HOME PHONE CELL E-MAIL

OCCUPATION HOBBIES Computer use? Yes No

When was your last eye exam? How old are your glasses? Sunglasses?

What kind of contacts have you worn in the past? Disposable Toric Hard/Gas Perm Conventional Yearly

Name of Contact Lens Brand?

Have you worn contacts in the last 24 hours? Yes No or the last time worn?

Have you slept in contact lenses? Yes No Would you like to sleep in contacts? Yes No

Eye History

Table with 3 columns: Symptom, Y, N. Includes items like Blurred Vision, Eye Pain, Itching, Burning, Floaters or spots, LASIK OR RK, etc.

Health History

Table with 3 columns: Symptom, Y, N. Includes items like Allergies, Gastrointestinal, Pregnant, current, Anxiety/Depression, Heart Trouble, Asthma, etc.

Family History

Table with 3 columns: Symptom, Y, N. Includes items like Arthritis, Heart disease, Retinal Detach, Color Blindness, High blood press, Stroke, etc.

Social History

This information is strictly confidential. However, you may discuss this portion with the doctor if you prefer.

Do you drink alcohol? Y N Occasional 1 per day? 2-3/Day? 4+/Day?

Do you use tobacco products? Y N Occasional? 1/2pack/day? 1pack/day? 1+pack?

Do you use illegal drugs? Y N

Please list any medications you are currently taking:

Do you have any sensitivity/allergy to any medications?

Statement of Financial Responsibility:

Initial: _____ I accept responsibility for payment in full for services rendered on the day of examination. If my insurance is accepted and does not reimburse the doctor's office, I understand I am responsible for payment.

Your doctor highly recommends:

The VISUAL FIELD, or *side vision test*, can aid in the early detection of many disorders as glaucoma, diabetic and hypertensive retinopathy, brain tumors and retinal detachments. It is especially important for people that have headaches, flashes of light, medications as plaquinel, a strong eyeglass Rx, or reduced vision without apparent reason. (The visual field screening is \$15)

Initial: _____ Yes, I do want the \$15 visual field exam Initial: _____ No, I do not want the visual field

The DILATION, or drops to temporarily enlarge your pupils, helps the doctor to see problems that you cannot feel or see until your vision is impaired. Dilation is important to rule out problems associated with high blood pressure, diabetes, headaches, migraines, floaters, a high eyeglass Rx, retinal problems, glaucoma, or family history of eye disease. (The dilation is included in your exam.)

Initial: _____ Yes, I want dilation Initial: _____ No, I do not want dilation Initial: _____ I will follow Dr rec

ALL RX'S EXPIRE IN ONE YEAR

Privacy Act: Sheryl Simms, O.D. and Associates will maintain the privacy of your health information and personal data. Your information will only be released upon your authorization. The law permits us to disclose your information for treatment, payment, and regular health care operations. Examples: Calling for confirming appointments, Sending recall cards, Referring to doctors for further evaluation, pharmacies, and your third parties insurance.

By signing below, I acknowledge that I have received and/or read the privacy notice from Dr. Simms and Associates.

Signed: _____ Date: _____

FOR ALL CONTACT WEARERS. Follow up care: There is no charge for this visit if WITHIN 60 DAYS of the initial visit. After 60 days, there will be a charge. A contact lens RX will not be released without proper follow-up care. Only one trial pair of contact lenses will be permitted per patient if Rx applicable.

Initial: _____

Vision Insurance

Insure Name: _____ Birth Date: _____ Relationship: _____

Insured Employer's Name: _____ Insurance Provider: _____

Insured Member ID number: _____ Insured Group Number: _____

Primary Medical Insurance

Insured Name: _____ Birth Date: _____ Relationship: _____

Insured Employer's Name: _____ Insurance Provider: _____

Insured Member ID Number: _____ Insured Group Number: _____