

WELCOME TO MULVANE VISION CARE

FOR OFFICE USE ONLY:

ACCOUNT # _____

(PLEASE PRINT)

TODAY'S DATE _____ DATE OF BIRTH ____ / ____ / _____ AGE ____ SEX: M F
FULL NAME _____ SOCIAL SECURITY # _____
Nickname or preferred to be called _____ EMPLOYER (or SCHOOL) _____
ADDRESS _____ OCCUPATION (or GRADE) _____
CITY _____ STATE _____ ZIP _____ BUS. PHONE _____
HOME PHONE _____ CELL PHONE _____ FAMILY PHYSICIAN _____
Address _____
EMAIL ADDRESS: _____ EMERGENCY CONTACT _____
Relationship to Patient _____
CHILD LIVES WITH: Mother - Father - Both - Grandparents - Other Address _____ Phone # _____

SPOUSE OR PARENT NAME _____ EMPLOYER _____
DATE OF BIRTH ____ / ____ / _____ AGE ____ SEX: M F OCCUPATION _____
SOCIAL SECURITY # _____

Have we seen anybody in your immediate family? Y N
If yes, may we have their name and relation? _____
If no, who referred you? Doctor ____ Friend ____ or other ____ (please specify) _____
List sports or recreational activities _____
List any Hobbies _____

How did you learn about our office?

- Friend/Relative Who? _____
- Another health care practitioner. Who? _____
- SWB Yellow Pages Newspaper Ad
- Insurance Other

DO YOU ...

- | | | |
|--|---|---|
| Have more than one pair of glasses? | Y | N |
| Want information on lighter, thinner lenses? | Y | N |
| Have prescription sunglasses? | Y | N |
| Have problems with glare or reflection, particularly
When driving at night? | Y | N |
| Work on a computer for long periods? | Y | N |

Do you have any allergies to medicines? Y N If yes, explain: _____

List any medicines you take (including oral contraceptives, aspirin, over the counter medications and home remedies):

List all major injuries, surgeries and/or hospitalizations you have had: _____

List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye injury. _____

Are you pregnant and/or nursing? Y N
Do you wear glasses? Y N If yes, how old is your present pair of lenses? _____
Do you wear contact lenses? Y N If yes, how old is your present pair of lenses? _____
Type of contact lenses: _____ → Rigid Soft Extended Wear Other Are they comfortable? Yes No

PAYMENT / CO-PAYMENT IS EXPECTED AT THE TIME OF SERVICE. THANK YOU!

I hereby authorize the release of any medical and/or other information necessary to process this claim. I also authorize my insurance benefits to be paid directly to the optometrist and understand that I will be financially responsible for any service not paid in full by my insurance Company.

SIGNED: _____ DATE: _____

Account will be settled today by: CHECK CASH CREDIT CARD INSURANCE

Doctor's Signature _____ DATE: _____

FAMILY HISTORY

Please note any family history (parents, grandparents, siblings, children, living or deceased) for the following conditions:

<u>DISEASE / CONDITION</u>				<u>RELATIONSHIP TO YOU</u>
Blindness	Y	N	?	_____
Cataract	Y	N	?	_____
Crossed Eyes	Y	N	?	_____
Glaucoma	Y	N	?	_____
Macular Degeneration	Y	N	?	_____
Retinal Detachment / Disease	Y	N	?	_____
Arthritis	Y	N	?	_____
Cancer	Y	N	?	_____
Diabetes	Y	N	?	_____
Heart Disease	Y	N	?	_____
High Blood Pressure	Y	N	?	_____
Kidney Disease	Y	N	?	_____
Lupus	Y	N	?	_____
Thyroid Disease	Y	N	?	_____
Other _____	Y	N	?	_____

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

____ **YES, I would prefer to discuss my Social History information with my doctor.**

Do you drive? Y N If yes, do you have visual difficulty when driving? Y N If yes, please describe: _____

Do you use Tobacco products? Y N If yes, type / amount / how long? _____

Do you drink alcohol? Y N If yes, type / amount / how long? _____

Do you use illegal drugs? Y N If yes, type / amount / how long? _____

Have you ever been exposed to or infected with: _____ Gonorrhea _____ Hepatitis _____ HIV _____ Syphilis

REVIEW OF SYSTEMS Do you currently, or have you ever had any problems in the following areas?

CONSTITUTIONAL

Fever, Weight Loss / Gain N Y ?

INTEGUMENTARY (Skin)

N Y ?

NEUROLOGICAL

Headaches N Y ?

Migraines N Y ?

Seizures N Y ?

EYES

Loss of Vision N Y ?

Blurred Vision N Y ?

Distorted Vision / Halos N Y ?

Loss of Side Vision N Y ?

Double Vision N Y ?

Dryness N Y ?

Mucous Discharge N Y ?

Redness N Y ?

Sandy or Gritty Feeling N Y ?

Itching N Y ?

Burning N Y ?

Foreign Body Sensation N Y ?

Excess Tearing / Watering N Y ?

Glare Light Sensitivity N Y ?

Eye Pain or Soreness N Y ?

Chronic Infection of Eye N Y ?

Sties or Chalazion N Y ?

Flashes / Floaters in Vision N Y ?

Tired Eyes N Y ?

ENDOCRINE

Thyroid / Other Glands N Y ?

EARS, NOSE, MOUTH, THROAT

Allergies / Hay Fever N Y ?

Sinus Congestion N Y ?

Runny Nose N Y ?

Post-Nasal Drip N Y ?

Chronic Cough N Y ?

Dry Throat / Mouth N Y ?

RESPIRATORY

Asthma N Y ?

Chronic Bronchitis N Y ?

Emphysema N Y ?

VASCULAR / CARDIOVASCULAR

Diabetes N Y ?

Heart Pain N Y ?

High Blood Pressure N Y ?

Vascular Disease N Y ?

GASTROINTESTINAL

Diarrhea N Y ?

Constipation N Y ?

GENITOURINARY

Genitals / Kidney / Bladder N Y ?

BONES / JOINTS / MUSCLES

Rheumatoid Arthritis N Y ?

Muscle Pain N Y ?

Joint Pain N Y ?

LYMPHATIC / HEMATOLOGIC

Anemia N Y ?

Bleeding Problems N Y ?

ALLERGIC / IMMUNOLOGIC

N Y ?

PSYCHIATRIC

N Y ?

If you answered YES to any of the above questions or have a condition not listed, please explain and list medications:

THANK YOU !!!!