

**WELCOME TO OUR OFFICE**  
**Dr. Lynn Burford,**  
**Optometrist**

Today's Date: \_\_\_\_\_

**Patient Information**

Last \_\_\_\_\_  
 First \_\_\_\_\_ MI \_\_\_\_\_  
 Ms Mrs Mr Dr  
 Street \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_  
 Zip Code \_\_\_\_\_  
 Home Phone \_\_\_\_\_  
 Work Phone \_\_\_\_\_  
 Cell Phone \_\_\_\_\_  
 Patient's SSN \_\_\_\_\_  
 Employer (or School) \_\_\_\_\_  
 Occupation (or Grade) \_\_\_\_\_  
 Spouse (or Parent's Name) \_\_\_\_\_  
 Spouse (or Parent's Work) \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
 Sex  M  F  
 Email Address \_\_\_\_\_  
 What would you like to be called? \_\_\_\_\_  
 Preferred contact number \_\_\_\_\_  
 What is the major purpose of this visit?  
 \_\_\_\_\_

Any problems with your current contact lenses or glasses?  
 \_\_\_\_\_  
 \_\_\_\_\_

***NEW PATIENTS ONLY:***

Whom may we thank for referring you to our office?  
 Name of friend or relative \_\_\_\_\_

If not referred, how did you choose our office?

- Another doctor
- Insurance List
- Saw Sign/Building
- Newspaper/Radio/TV
- Yellow Pages:
- Other

***Our mission is to provide the highest quality eye care and excellent customer service in a professional, friendly environment. We pledge to remain at the technological forefront of our profession, with the needs and concerns of each patient always being our first priority. Everything we do shall communicate this.***

**Insurance Information**

***Lens Follow-Up Evaluation.***

Vision Insurance \_\_\_\_\_  
 Subscriber Name \_\_\_\_\_  
 Subscriber SSN \_\_\_\_\_  
 Subscriber Birth Date \_\_\_\_\_  
  
 Primary Medical Insurance \_\_\_\_\_  
 Subscriber Name \_\_\_\_\_  
 Subscriber SSN \_\_\_\_\_  
 Subscriber Birth Date \_\_\_\_\_

**Lifestyle Questions**

**Do you.....(check box if your answer is yes)**

- ..work at a computer? If yes, please complete computer questionnaire.
- ..think you might benefit from thinner, lighter lenses?
- ..have interest in a "test drive" of the latest contact lens designs
- ..spend time outdoors? How much? \_\_\_Hrs/week
- ..have prescription sunwear?
- ..prefer not to wear your glasses at times?
- ..want information on Laser Vision Correction surgery?
- ..have interest in a non-surgical approach to vision correction?
- ..have more than 1 pair of current Rx eyewear?

**Eye History**

**Have you ever experienced, been diagnosed or treated for any of the following?**

- |  |  |
|--|--|
| <input type="checkbox"/> Blurry Vision             | <input type="checkbox"/> Burning                 |
| <input type="checkbox"/> Cataracts                 | <input type="checkbox"/> Corneal Abrasions       |
| <input type="checkbox"/> Crossed eye/Eye turn      | <input type="checkbox"/> Double Vision           |
| <input type="checkbox"/> Eye Infections            | <input type="checkbox"/> Eye Injury              |
| <input type="checkbox"/> Flash of light            | <input type="checkbox"/> Floaters/Spots          |
| <input type="checkbox"/> Glaucoma                  | <input type="checkbox"/> Grittiness              |
| <input type="checkbox"/> Headaches                 | <input type="checkbox"/> Iritis/Uveitis          |
| <input type="checkbox"/> Itchy eyes                | <input type="checkbox"/> Lazy Eye                |
| <input type="checkbox"/> Macular Degeneration      | <input type="checkbox"/> Occasional dryness      |
| <input type="checkbox"/> Retinal Detachment        | <input type="checkbox"/> Sunlight Sensitivity    |
| <input type="checkbox"/> Tearing                   | <input type="checkbox"/> Trouble seeing at night |
| <input type="checkbox"/> Uncomfortable glasses     |  |
| <input type="checkbox"/> Other eye disorders _____ |  |

The information in this confidential case history form is critical to the evaluation of your vision and health.

Patient Medical History	
Name of Family Physician _____ Town _____ Date of Last Physical Check-up _____	
<b>CURRENT MEDICATIONS (Rx or Over the Counter)</b> (List name of medications including eye drops, vitamins, & birth control pills) _____ _____	
Allergies to medications? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, what medications? _____ _____	
Have you had any surgeries? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you use cigarettes/tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No Alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No Other substances? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Have you ever been diagnosed or treated for the following health problems?</b>	
	<b>Yes</b>
Allergies	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>
Cancer	<input type="checkbox"/>
Cholesterol	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>
Neurological	<input type="checkbox"/>
Sinus	<input type="checkbox"/>
Thyroid	<input type="checkbox"/>
Unusual weight losses/gains	<input type="checkbox"/>
Pregnant or Nursing	<input type="checkbox"/>

Patient Eye History	
Date of Last Eye Exam _____ By Whom? _____	
Have you ever tried contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you currently wear contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No What kind? _____ Solutions used _____	
Are you satisfied with the vision and comfort of your contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Would you prefer clear contact lenses or colored contact lenses? <input type="checkbox"/> Clear <input type="checkbox"/> Colored	
If you wear bifocals, do the lines or head tilting bother you? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Family Medical/Eye History (Check all that apply)	
Is there a family medical history of any of the following: <input type="checkbox"/> No <input type="checkbox"/> Yes (Please check boxes)	
	Relationship (Mother's or Father's side)
Blindness	<input type="checkbox"/> _____
Cataracts	<input type="checkbox"/> _____
Corneal Problems	<input type="checkbox"/> _____
Diabetes	<input type="checkbox"/> _____
Glaucoma	<input type="checkbox"/> _____
Heart Disease	<input type="checkbox"/> _____
Lazy Eye	<input type="checkbox"/> _____
Macular Degeneration	<input type="checkbox"/> _____
Retinal Problems	<input type="checkbox"/> _____

Please be advised if you are using insurance coverage for today's visit, this is a contract between you and your insurance company.
If we are not a participating provider for your plan, we ask that you pay us and we will be happy to file a claim for you. Most non-participating plans will reimburse the patient directly.
Signature _____