

Today's Date _____

Patient Information

Last _____
 First _____ MI _____
 Street _____
 City _____ State _____
 Zip Code _____
 Home Phone _____
 Work Phone _____
 Patient's SSN _____
 Employer (or School) _____
 Occupation (or Grade) _____
 Date of Birth _____ Age _____
 Sex M F
 Spouse (or Parent's) Name _____
 Spouse (or Parent's) Work _____
 Patient Marital Status Married Single Other
 Email Address _____

What is the major purpose of this visit?

Any problems with your current contact lenses or glasses?

VERY IMPORTANT! NEW PATIENTS ONLY:

Who may we thank for referring you to our office?
 Name of friend or relative _____
 If not referred, how did you choose our office?
 Another Dr.
 Insurance List
 Saw Sign/Building
 Newspaper/Radio/TV
 Yellow Pages: Which directory? _____
 Web Page: Which Web Site? _____
 Other _____

The mission of Precision Eye Care, DBA Salt Lake Vision is to provide you with professional, accurate and thorough eye and vision care in a friendly and caring environment. We are also committed to providing you with high quality products and services that will best meet your eye and vision care needs. Our goal is to enhance the quality of life for you, your family, and your community for many years to come. Thank you in advance for allowing us to serve you and fulfill our mission.

Please Complete Other Side ↓

Insurance Information

Please note that certain insurances do NOT cover the Contact Lens Fitting and Follow-Up Evaluation.

Vision Insurance _____
 Subscriber Name _____
 Subscriber SSN _____
 Subscriber Birth Date _____
 Subscriber Work Place _____
 Primary Medical Insurance _____
 Subscriber Name _____
 Subscriber SSN _____
 Subscriber Birth Date _____
 Subscriber Work Place _____

Do you participate in a flex spending account?
 Yes No
 How will you settle your account today?
 Cash Check Credit Card

Lifestyle Questions

Do you.....(check box if your answer is yes)
 ..work at a computer? If yes, please describe what problems if any you may be having? _____

 ..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?
 ..have children?
 ..have family members in need of eyecare?
Have you ever experienced, been diagnosed or treated for any of the following?
 Blurry Vision Burning
 Cataracts Corneal Abrasions
 Crossed eye/Eye turn Double Vision
 Eye Infections Eye Injury
 Flash of light Floaters/Spots
 Glaucoma Grittiness
 Headaches Iritis/Uveitis
 Itchiness Lazy Eye
 Macular Degeneration Occasional dryness
 Retinal Detachment Sunlight Sensitivity
 Tearing Trouble seeing at night
 Uncomfortable glasses
 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	_____	
CURRENT MEDICATIONS (Rx or Over the Counter)		
(List name of medications including eye drops, vitamins, & birth control pills)_____		

Are you currently pregnant or nursing?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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, alcohol, or other substances?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any sexually transmitted diseases (STDs)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been diagnosed or treated for the following health problems?		
	Yes	No
Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Blood/Lymph	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Digestive	<input type="checkbox"/>	<input type="checkbox"/>
Ears/Nose/Throat	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine	<input type="checkbox"/>	<input type="checkbox"/>
Eczema/Rashes	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Fevers	<input type="checkbox"/>	<input type="checkbox"/>
Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Integumentary (Skin)	<input type="checkbox"/>	<input type="checkbox"/>
Kidney	<input type="checkbox"/>	<input type="checkbox"/>
Muscle/Bone	<input type="checkbox"/>	<input type="checkbox"/>
Neurological	<input type="checkbox"/>	<input type="checkbox"/>
Psychological	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>
Sinus	<input type="checkbox"/>	<input type="checkbox"/>
Throat Infections	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Unusual weight losses/gains	<input type="checkbox"/>	<input type="checkbox"/>

Patient Eye History
Date of Last Eye Exam_____
By Whom?_____
Have you tried contact lenses in the past? If not would you be interested in a free trial pair of 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 and/or colored contact lenses? <input type="checkbox"/> Clear <input type="checkbox"/> Colored <input type="checkbox"/> Both
If you wear bifocals, do the lines or head tilting bother you? <input type="checkbox"/> Yes <input type="checkbox"/> No
Would you like to be free from glasses and/or contacts? <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"/> _____

I authorize the release of any information required in the course of my examination and treatment by the optometrist. I authorize the payment of medical benefits to the optometrist providing eye care to me.

I/We agree to the following policies regarding payment:

- All co-pays and/or examination fees are due at the time of service.
- At least 50% of the cost of glasses and/or contacts is due upon ordering, and the remainder is due at the pick up date.
- Pay all attorney fees, court costs, filing fees, and all collection costs if the above policies are not followed. Up to 50% of the amount owing may be assessed by any collection agency. Pay interest at the rate of one and one half percent per month or 18% per year.
- Pay the balance in full if my insurance company does not cover the entire balance of this account.
- There are no refunds.** However, we can re-do lenses one time at no cost to you (within 60 days of exam if there is a change in rx) and most lenses, frames and contacts have warranties. Also we ensure that you are satisfied with your disposable contact lenses before ordering. However, if we cannot meet your satisfaction with glasses, and at the doctor's discretion, a partial refund may be given (the amount paid over the wholesale cost of the glasses, as this amount cannot be recovered).

Signature_____

Date_____

