WELCOME TO

New Vision Center

We are pleased that you have chosen our office for you vision care.

Patient Name:		D.O.B	Sex: M F	Date:
Address:		Apt. #:	Home Phone #:	
City:	State:	Zip code:	Alternative Phone #:	

How did you hear of our office? _____

Employer: _____ Occupation:_____

Responsible Party:_____ Patient SS#:_____

Vision Insurance:_____ Self_____ spouse_____ other_____

Insured's Name:_____ D.O.B of the insured:_____

Insurance authorization: I hereby authorize the physician(s) indicated to furnish information to insurance carriers concerning my eye's problems and/or treatments and I hereby irrevocably assign to the physicians all payments for services rendered to myself or to my dependents. I understand that I am financially responsible for all charges whether or not covered by insurance. A photocopy of this authorization shall be considered as effective and valid as the original.

Initials:_____ payment form: ____cash ____credit card ____check Drivers License#:_____

Last Eye Exam:_____/_____/_____ Have you worn glasses?:_____

Do you wear contact lenses?:_____ Type:_____ How long?:_____

Your reasons for visiting our office today (Please check all that apply).

___General check up ___Want new glasses
___Headaches ___Blurred distance vision
___Eye infection ___Want to know contact lens options
___Want contact lenses: ___Soft(__disposables __daily __colored) __Gas Permeable __Other

What specific problems do you have with your eyes or vision?:_____

_____

Hobbies?:_____

Please check any medical/ocular conditions that apply to **YOU:**

__Diabetes	__Flashes	__ Alcohol	__Eye Injury	__Multiple sclerosis	__Circulatory Problem
__Stroke	__Arthritis	__ Tobacco	__Eye surgery	__Macular degeneration	__Retinal detachment
__Allergies	__Cancer	__Glaucoma	__Migraines	__High blood pressure	__Corneal Disease
__Floaters	__Cataract	__Lazy eye	__Heart disease	__Respiratory problem	__Other

Has any blood relative had any of the above conditions? If yes Please list: _____

_____

List **all medications** taken presently: _____

Any **drug allergies**? If so, please list medications.: _____

Pupil Dilation

Dilating drops last about 4 to 6 hours and allow the doctor to perform a more thorough examination of your retina (back of the eye). You may be able to drive, but it is recommended that someone else drive you home. Dilation can assist in early detection of glaucoma, cataract, retinal, and neurological diseases. **There is an extra charge of $20 to be dilated.** We strongly recommend that you are dilated with each exam. Please indicate your preference.

___I **want** to be dilated today ___I **want** to be dilated **later** __I **do not want** to be dilated

Visual Field Screening

Visual field analysis is one of the most sensitive tests available in diagnosing conditions such as glaucoma, retinal problems, neurological diseases (brain tumors and optic nerve disease). Most visual field defects are not noticed by an individual until in the very late stages. We are committed to prevention of eye diseases as well as early detection, which significantly increases the chances of curing the disorder, or at least minimizing its effects. **A screening test can be performed in less than 10 minutes for an additional charge of $20.** Please indicate your preference

___I **want** the visual field screening test ___**I do not want** the visual field screening test

NOTEThis is a screening. It is possible that an additional comprehensive visual field testing may be necessary based on the results of your vision analysis by the doctor.

PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED UNLESS OTHER ARRANGEMENTS ARE MADE IN ADVANCE.
THANK YOU. ALL PROFESSIONAL FEES ARE NON-REFUNDABLE

X_____ _____

Signature of Patient or Responsible Party **Date**