

ADVANCED FAMILY EYE CARE

William G. Richey, O.D.

Welcome To Our Office

Today's Date _____
Last _____ First _____ MI _____
Street _____
City _____ State _____ Zip _____
Home Phone _____
Work Phone _____
Patient's Social Security Number _____
Employer (or School) _____
Occupation _____
Spouse (or Parent's) Name _____
Spouse (or Parent's) Work _____
Date of Birth _____ Age _____ Sex M ___ F ___
E-mail address _____ Can we contact you? ___

What is the major purpose of this visit?

Any problems with your present contact lenses or eyeglasses?

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 for your needs?

Another Dr. _____ Insurance List _____
Saw Sign/Building _____ Newspaper/Radio/TV _____
Yellow Pages. Which directory? _____
Web Page. Which web site? _____
Other _____

Insurance Information

Vision Insurance: _____
Subscriber Name: _____
Subscriber Social Security Number: _____
Subscriber Birth Date: _____

Primary Medical Insurance: _____
Subscriber Name: _____
Subscriber Social Security Number: _____
Subscriber Birth Date: _____

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

Family Medical/Eye History (Check all that apply)

Is there a family medical history of any of the following?

	Relationship
Blindness	_____
Cataracts	_____
Corneal Problems	_____
Glaucoma	_____
Lazy Eye	_____
Macular Degeneration	_____
Retinal Problems	_____
Diabetes	_____
Heart Disease	_____

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 and birth control pills) _____

Allergies to Medications: Yes No

Have you ever been diagnosed or treated for the following?

Allergies	Diabetes	Thyroid
Asthma	Heart Disease	Other _____
Arthritis	High Blood Pressure	_____
Cancer	Kidney	
Cholesterol	Nerves	

Patient Eye History

Date of Last Exam _____
By Whom? _____
Do you currently wear contact lenses? Yes No
What kind? _____
Solutions used _____
Would you prefer clear contact lenses or colored contact lenses to change the color of your eyes? _____
Have you ever tried contact lenses? Yes No

Do you.....(Check if your answer is yes)

___ Work at a computer?
___ Sometimes experience dry eyes?
___ Think you might benefit from thinner, lighter lenses?
___ Have an interest in a "Test Drive" of the latest contact lens design?
___ Spend time outdoors? (How much?) _____ hrs/week
___ Have prescription sunglasses?
___ Prefer not to wear your glasses at times?
___ Want information on Laser Vision Correction?
___ Have more than 1 pair of current Rx glasses?
___ Have children?
___ Have family members in need of eye care?

If you wear bifocals, are you bothered by the lines or head tilting? Yes No

If you wear contact lenses, are you satisfied with the vision and the comfort? Yes No

Have you ever been diagnosed or treated for the following?

Cataracts	Iritis/Uveitis
Corneal Abrasion	Lazy Eye
Eye infection	Macular Degeneration
Eye injury	Retinal Detachment
Glaucoma	Other eye disorders

Do you experience or have you ever experienced?

Blurry vision	Flash of light	Sunlight sensitivity
Burning	Floater/spots	Tearing
Crossed eye/eye turn	Grittiness	Double vision
Headaches	Severe dryness	Itchiness
Uncomfortable glasses	Trouble seeing at night	