Charles Adams, O.D.

WELCOME TO OUR OFFICE

Today's Date ____________
Last ________ First ________ MI ____
Street ____________
City ________ State ________ Zip Code ____
Cell Phone ____________
Work Phone ____________
Patient's SSN ____________
Employer (or School) ____________
Occupation (or Grade) ____________
Spouse (or Parent's Name) ____________
Spouse (or Parent's Work) ____________
Patient's Date of Birth__________ Age_____ Sex M F
Email Address ____________
What is the major purpose of this visit? ____________

Any problems with your present lenses or glasses?

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
- ☐ Other

Insurance Information

Vision Insurance ____________
Subscriber Name ____________
Subscriber SSN ____________
Subscriber Birth Date ____________

I certify that I, or my dependent, has insurance coverage with the insurance companies listed above and hereby assign directly to Dr. Charles S. Adams, O.D. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges incurred regardless of payment by the insurance company. I hereby authorize the physician to release all information necessary to secure the payment of benefits. I also authorize the use of this signature on all insurance submissions.

Responsible Party's Signature ____________ Date ____________

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	☐	

Doctor's Initials

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 ____________
Date of Last Physical Check-up ____________
Have you had any operations? (list) ____________
Do you use, Tobacco, Alcohol, or other substance? ____________

CURRENT MEDICATIONS (Rx or Over the Counter)
(List name of Medications including eye drops, vitamins, & 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 Eye 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 box if your answer is yes)

- ☐ ..Work at a computer?
- ☐ ..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 surgery?
- ☐ ..Have interest in a non-surgical approach to vision correction?
- ☐ ..Have more than 1 pair of current Rx glasses?
- ☐ ..Have children?
- ☐ ..Have family members in need of eyecare?

If you wear bifocals, do the lines or head tilting bother you? ☐ Yes ☐ No
If you wear contact lenses, are you satisfied with the vision and 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
- ☐ Crossed eye/eye turn
- ☐ Tearing
- ☐ Grittiness
- ☐ Trouble seeing at night
- ☐ Double vision
- ☐ Itchiness
- ☐ Uncomfortable glasses
- ☐ Occasional dryness

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it. Initials ____