PATIENT INFORMATION (Please Print)				
Last Name	First Name	M.I.	Age	Birthdate
Address	City State Zip Code			Home Phone ( )
Email	Occupation			Cell Phone ( )
Vision Insurance, if any: Please check ____ Spectera/ Secure Horizon/ United Health Care ____ VSP (Vision Service Plan) ____ Costco MES employee & dependents ____ Superior Vision ____ MES (Medical Eye Services) ____ Davis Vision/FED Blue Vision ____ ***No Vision Insurance/ Self-Pay***	Name of Insurance Policy Holder ID# of Insurance Policy Holder		SS# of Insurance Policy Holder Birthdate of Insurance Policy Holder	

#_____ OptoMap

1. Do you feel your distance vision is changing? ___YES ___ NO
2. Do you feel your near vision is changing? ___ YES ___ NO
3. Please check/circle if ***you*** have any of the following since your last visit in our office: (Please check/circle all that applies)
   - ___ Floaters/flashes of light
   - ___ Dry, burning, or watery eyes
   - ___ Double vision
   - ___ Allergies with itchy eye
   - ___ Frequent headaches related to your eye
   - ___ Other new medical history (specify)_____
   - ___ High blood pressure
   - ___ Diabetes
   - ___ Elevated cholesterol
   - ___ Thyroid condition
   - ___ Cancer / stroke / heart disease
4. When was your last full medical/physical exam with your family physician? _____
5. If female, are you pregnant or nursing? ___ YES ___ NO
6. Do you smoke? ___ YES ___ NO
7. Do you have sleep apnea? ___ YES ___ NO
8. Are you currently taking any medications and/or vitamins? ____YES ____NO
   Please list _____
9. Are you allergic to any medications or eye drops? ___ YES ___ NO Please list _____
10. Have you had any recent eye injury, infection and/or eye surgery since your last visit in our office? ___YES ___NO
    Please specify_____
11. How many hours are you on the computer per day? _____

3-D OPTOMAP RETINAL IMAGING (dilation not necessary)

Viewing the retina inside your eyes is necessary in order to ensure optimal eye health. Many eye diseases can be diagnosed early through retina imaging which otherwise may not be detected. The retinal images will become a permanent record to compare year after year. The procedure is comfortable, painless and dilation is not necessary.

The cost of having your eyes 3-D imaged is $29 .(not cover by insurance)

Please Initial: _____ I ***consent*** for OptoMap Imaging

_____ I ***decline*** to have OptoMap Imaging at this time.

I am aware that my records will not be released without my written authorization in accordance with HIPPA policies. This office is an Independent Optometry Practice. Payment is due at the time of service and is non-refundable.

_____ _____

Patient Signature (if under 18, parent signature required) Date

CONTACT LENS HISTORY (if currently wearing contacts)

12. Do you sleep with your contact lenses? ___ YES ___ NO How many days per week? _____
13. Are you happy with your current contact lens brand? ___YES ___NO
14. How often do you replace your contacts? _____
15. How old are your current contacts? _____
16. What lens care system do you currently use? ___ Alcon Opti-Free Replenish/ Pure Moist
    - ___ B&L Renu/ BioTrue
    - ___ Clear Care System
    - ___ Other (specify)_____