

GOLDEN EYE CLINIC

Name: _____ Date of Birth: _____ Today's Date: _____

Thank you for entrusting the health of your eyes to us. Our commitment is to provide you with the highest standards of care in an open, honest environment. To help us serve you best, please answer the questions below so we can learn more about your vision and how you use your glasses or contacts. Our highly-trained staff will use this information to provide a vision solution that meets your needs.

Family Doctor: _____ Last Eye Exam? _____ By whom? _____

Chief Complaint: Blurred Vision Glaucoma Eye Infection – red eye
 Eye Injury Need new glasses Need refill on contact lenses

Reason for today's visit: " _____."

Have you developed any other medical concerns you wish to discuss today? _____

Please describe any changes in your medical history since your last visit? _____

Please list all medications you are currently taking: _____

Would you prefer to be dilated today or have an optomap test (no dilation required) for an additional \$25?
Please check one: ___ Dilation ___ Optomap (\$25 extra)

Will we be filing on any insurance today? _____ If so, please give the receptionist your insurance card to copy.

Would you be interested in Lasik surgery? _____

Do you experience difficulty with nighttime vision, like glare when driving at night? _____

Are you constantly going in and out of sunlight throughout the day? _____

How many hours per day do you spend on the computer or with hobbies that require close vision? _____

Are you experiencing eyestrain, vision fatigue or headaches? _____

Do you currently wear glasses? _____ If so, do you wear them all day? _____

Do you need bifocal correction, but dislike having a bifocal line on your lenses? _____

CONTACT LENS PATIENTS ONLY

How long have you been wearing contact lenses? _____

Are you having any problems with your current contacts? _____

Do you ever sleep in your contacts? _____

How often do you throw your contact lenses away? _____

If a better type of contact is now available for you, would you mind trying it? _____

RELEASE & AUTHORIZATION: I hereby authorize release of any information concerning my (or my child's) examination and treatment provided for the purpose of evaluation and administering claims for insurance benefits. I also authorize payment directly to the doctor for any insurance benefits otherwise payable to me. I realize this may not represent full payment and understand I will be responsible for the balance due after any insurance is collected.

Signature of Patient or Personal Representative

Relationship to Patient

Today's Date