Guardian: _____

Name: _____

Address: _____

City, St: _____ **Zip:** _____

Phone(H): _____ W: _____ C: _____

Date of Birth: _____ **Sex:** _____

E-Mail: _____

Occupation: _____

Notify me by: ☐ Text ☐ Phone ☐ Email ☐ Mail

Who may we thank for referring you to our office?

☐ Friend ☐ Insurance ☐ Phone Book ☐ Other...

Emergency Contact Name and Phone:

_____

Approx. Date of Last Eye Exam: _____

What is the major purpose of this visit:

☐ Blur at Far
☐ Blur at Near
☐ Blur at Far & Near
☐ Itching
☐ Burning
☐ Redness
☐ Eye pain
☐ Eye strain
☐ Flashes/Floaters
☐ Loss of vision
☐ Double vision
☐ Sandy/Gritty
☐ Spots or shadows
☐ Diabetes eye check
☐ Medical eye check
☐ Other...

Which Eye? ☐ Right eye ☐ Left eye ☐ Both eyes

How long has it bothered you?

☐ Started today ☐ 1-2 days ☐ 3-7 days
☐ 1-2 weeks ☐ 2-4 weeks ☐ 1-3 months
☐ 3-6 months ☐ Over 6 months

Severity? ☐ Mild ☐ Moderate ☐ Severe

Getting Worse?

☐ Getting better ☐ Getting worse ☐ About the same

Current Prescription:

Glasses: Right _____

Left _____

Contacts: Right _____

Left _____

Medical Doctor(s):

AMERICAN FORK VISION CENTER

24 West Main
American Fork, UT 84003
(801) 756-7996
Fax: (801) 756-1690

Race
○ American Indian or Alaska Native
○ Asian
○ Black or African-American
○ Native Hawaiian or Other Pacific Islander
○ Other Race
○ Unknown/undetermined
○ White

Ethnicity ○ Hispanic or Latino ○ Unknown ○ Not Hispanic or Latino

Language ☐ English ☐ French ☐ Russian ☐ Other... ☐ Spanish ☐ Japanese ☐ Chinese

Smoking
☐ 1 Current everyday smoker
☐ 2 Current some day smoker
☐ 3 Former smoker
☐ 4 Never smoker
☐ 5 Smoker, current status unknown
☐ 9 Unknown if ever smoked

Please note that insurance does NOT cover the Contact Lens Fitting Evaluation

Vision or Primary Insurance

Ins. Name: _____

Ins Number: _____

Relationship: _____

Insured: _____

Insured DOB: _____ **Ins. Sex:** ○ M ○ F

Co-pay: _____ **Materials:** ○ Y ○ N

Medical or Secondary Insurance

Ins. Name: _____

Ins Number: _____

Relationship: _____

Insured: _____

Insured DOB: _____ **Ins. Sex:** ○ M ○ F

Co-pay: _____ **Materials:** ○ Y ○ N

Participate in a flex spending account? ☐ Y ☐ N

Past Medical History

- ☐ Allergy
- ☐ Amblyopia
- ☐ Asthma
- ☐ Cancer
- ☐ Cataract
- ☐ Crossed Eyes
- ☐ Diabetes 1
- ☐ Diabetes II
- ☐ Droopy Lid
- ☐ Ear
- ☐ Ear Problem
- ☐ Eye Infection
- ☐ Eye Injury
- ☐ Eye Surgery
- ☐ Gastrointestinal
- ☐ Glaucoma
- ☐ Heart
- ☐ Heart disease
- ☐ Herpes
- ☐ High B.P.
- ☐ Keratoconus
- ☐ Kidney
- ☐ Lasik
- ☐ Lazy Eye
- ☐ Lupus
- ☐ Macular Degen.
- ☐ Migraine
- ☐ MS
- ☐ Psychological
- ☐ Sinus
- ☐ Sinusitis
- ☐ Thyroid
- ☐ Other...

Eye wear History

- ☐ Glasses
- ☐ Bifocals
- ☐ Trifocals
- ☐ No- line
- ☐ Soft Contacts
- ☐ Toric Soft
- ☐ Gas Perm
- ☐ Hard
- ☐ Monovision
- ☐ Disposable
- ☐ Overnight wear

Mark box if yes.

- ☐ Have you tried contact lenses?
- ☐ Not satisfied with the vision comfort of your contact lenses?
- ☐ Would prefer colored contacts?
- ☐ Do the lines and head tilting bother you with bifocals?

Allergies

- ☐ None
- ☐ Penicillin
- ☐ Sulfa
- ☐ Eye drops
- ☐ Other...

Social History

- ☐ Computer
- ☐ Reading
- ☐ Student
- ☐ Music
- ☐ Skiing
- ☐ Golf
- ☐ Fishing
- ☐ Tennis
- ☐ Swim
- ☐ Bike
- ☐ Drug Abuse
- ☐ Alcohol Abuse
- ☐ No alcohol or drug abuse
- ☐ Other...

Current Medicines — Amount

Family History

- ☐ Blindness
- ☐ Cataracts
- ☐ Crossed Eyes
- ☐ Color Blind
- ☐ Diabetes
- ☐ Kidney Disease
- ☐ Macular Degen.
- ☐ Retina Disease
- ☐ Retina Detach
- ☐ Heart Disease
- ☐ High B.P.
- ☐ Thyroid
- ☐ Glaucoma
- ☐ Cancer
- ☐ None
- ☐ Other...

Lifestyle Questions

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

- ☐ Work at a computer often?
- ☐ Think you might benefit from thinner lenses?
- ☐ Would like to "test drive" the latest contact lenses?
- ☐ Spend time outdoors?
- ☐ Prefer not to wear your glasses at times?
- ☐ Want info. on Laser Vision Correction surgery?
- ☐ Have more than 1 pair of current Rx eyewear?

Many of our patients have both health and vision insurance and our office will bill each separately for the appropriate professional services. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance. Please feel free to ask our staff if you have any questions about insurance coverage.

_____I understand that if my vision insurance does not cover any additional recommended medical test that they can be billed to my medical insurance. Any services not covered by your insurance (Medicare/Medicaid, Altius, Cigna etc..) may be discounted and billed directly to you.

Are you planning on purchasing glasses today? ☐ Yes ☐ No

Signature_____ Date_____

Order Today:____10-2 ____30-2 ____abn ____asp ____fp ____gon ____oct/glauc ____oct/ret____pac ____print rx ____quote ____rush ____sp disc ____top ____fax report ____misc
Specs:_____2nd pair ____adjust ____ar___aspheric ___ft____hi ____new____otc____pc/tri____pge____plsg____prog____repair____sunclip ____tint____trans____update____uv____misc
Contacts:____1yr____burx____ccsol____gp____nf disp____polish____spgp____trial____misc
Rtc: ____10-2 ____30-2 ____asp ____ bst____cee____clex____clck____clck/fup____dfe____eo____fp_____fup____gon____ oct/ret____oct/glauc ____pac____po sx____pp ____top_____misc