Welcome to our office!

Patient's name_____Date of birth___/___/___

Name you prefer to be called_____

Address_____city_____ state___zip_____

Best phone number_____ Circle one: cell or home

E-mail address_____

Emergency contact & phone number _____

Date of last eye exam_____

Race:_____ Ethnicity: ☐ Hispanic ☐ Non- hispanic Gender: ☐ Male ☐ Female

Vision Insurance_____ Medical Insurance_____

Primary policy holder:

Full Name_____ DOB_____SSN_____

Specific vision needs and concerns today_____

Are you experiencing any of the following:

___blurry vision ___dry eyes ___itchy eyes ___watery eyes ___flashes of light ___floaters

Have you had previous eye surgery? ___ yes ___no What type? _____

How did you hear about our office?_____

I authorize the release of any medical information necessary to provide the most beneficial and complete visual examination. I understand that I am financially responsible for all charges whether or not paid by insurance. Payment is due at the time services are rendered, unless we are contracted with your insurance company and then we will bill for the covered services only. I understand that there are no refunds for services rendered at Coriell EyeCare.

Signature_____

I have been offered the Privacy Policy and Procedures by Coriell Eyecare and know that I can have a copy of these policies at any time. Initials_____

Medical History

Please check if you have problems with any of the following:

__diabetes	__blood/lymph	__ear/nose/throat
__high blood pressure	__allergies	__muscle problems
__thyroid	__cancer	__headaches
__skin/rashes	__genital/urinary	__lung/respiratory
__heart disease	__depression	__high cholesterol

Allergies to medications_____

Other allergies_____

Medications currently taking_____

Do you smoke? Yes___no___Drink alcohol? Yes___no___ Use other substances? yes___no___

Are you **pregnant or nursing**? yes___no___

Does anyone in your family have the following:

___diabetes	___high blood pressure	___retinal detachment
___glaucoma	___macular degeneration	___other eye disease_____

Optomap

As a part of your yearly eye exam, both Dr. Coriell and Dr. Cooper recommend the Optomap. The Optomap is a non-dilated retinal scan that checks on the health of the back of your eyes. Not only is this scan more convenient for you (no blurry vision, no light sensitivity and it takes half the amount of time to complete with instant results), this is the doctors' preferred way to monitor your eye health. We will be viewing your retina, macula and your retinal vessels to look for any defects or abnormalities. We recommend this procedure for both children and adults. Insurance does not cover this procedure and there is a $30 charge for this service. Please direct any questions to the technician who takes you back to begin your exam.

Signature_____date_____

Contact lenses

Please check:

___ I currently wear contacts

___ I do not wear contacts at this time but have in the past

___ I have never worn contact lenses

Please check if applies:

___ I would like today's exam to include a contact lens evaluation/examination (this allows me to order contacts for one year following my exam and there is a fee of $60/$80/$100)

___ I am interested in information about LASIK

Eyewear/Life Style Questionnaire

Occupation:_____

Hobbies: _____

Eyewear currently using:

contacts___ full-time glasses ____ glasses only when not wearing CLs____ reading glasses ____ safety glasses___ prescription sunglasses____ computer glasses____ glasses for driving only____ glasses for sports/hobbies___

Which of the following do you do regularly? Check all that apply.

work outdoors ___ drive for work ___ alternate from indoors to outdoors frequently___

work on a computer for 3+ hours___ frequent night driving___ work under fluorescent light___

Doctor Recommendations (leave blank for doctor):

___ needs RX update ____no change in RX ___polarized suns ____computer RX ___driving only

___reading only ___progressive lenses ___anti-reflective coating ___transitions ____high index