

WELCOME FORM

Name: _____ Today's Date _____

NO CHANGE OF ADDRESS OR PHONE NUMBERS

* Please verify with staff that we have your most current information on file *

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____ Alternate Phone: _____

Guardian (If Applicable): _____ Occupation: _____

Birth Date: _____ Email: _____

Preferred Method of Contact: Email Phone Call Text Message

Name of Medical Doctor: _____ Dr's Phone (If Applicable): _____

Medical History Update

Do you have any allergies to medications? No Yes If yes, please explain: _____

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies)

Are you pregnant and/or nursing? No Yes

Since your last visit have you had any problems with the following?

Loss of Vision No Yes

Tired Eyes No Yes

Blurred Vision No Yes

Foreign Body Sensation No Yes

Distorted Vision No Yes

Excess Tearing/Watering No Yes

Loss of Side Vision No Yes

Glare/Light Sensitivity No Yes

Double Vision No Yes

Eye Pain or Soreness No Yes

Flashes or Floaters No Yes

Chronic Infection of Eye No Yes

Itching in Eye No Yes

Chronic Infection of Lid No Yes

Burning in Eye No Yes

Sties No Yes

Contact Lens Patients

How old is your present pair of lenses? _____

Are your lenses comfortable? No Yes

How often do you replace your lenses? _____

Do you wish to have the doctor determine your contact lens prescription and/or maintain a current contact lens prescription?

No Yes

The fees associated with contact lens exam are particular to each patient's needs, and the fees are in addition to your comprehensive eye exam. Please feel free to ask our staff for more information. Please Initial: _____

LIFESTYLE QUESTIONNAIRE

NAME _____ DATE _____
OCCUPATION _____ YEARS _____ EMPLOYER _____

This questionnaire is designed to assist your eye care professional in helping you select the appropriate lenses, frames and/or contact lenses to suit your visual needs and lifestyle. Please take a few moments to answer the following questions.

1. Which of the following activities do you participate in? (Check all that apply)

- | | | | |
|-----------------|--------------------------------|-------------------------------------|---------------------------------------|
| Reading | <input type="checkbox"/> Daily | <input type="checkbox"/> Frequently | <input type="checkbox"/> Occasionally |
| Watching TV | <input type="checkbox"/> Daily | <input type="checkbox"/> Frequently | <input type="checkbox"/> Occasionally |
| Driving | <input type="checkbox"/> Daily | <input type="checkbox"/> Frequently | <input type="checkbox"/> Occasionally |
| Sports/Exercise | <input type="checkbox"/> Daily | <input type="checkbox"/> Frequently | <input type="checkbox"/> Occasionally |
- Computer
- | | |
|-----------------------------------|----------------------------|
| <input type="checkbox"/> Desktop | Hours per day . |
| <input type="checkbox"/> Laptop | Distance from screen . |
| <input type="checkbox"/> Handheld | (iPhone, Blackberry, etc.) |

- HOBBIES**
- Arts/Crafts
 - Boating
 - Drawing/Painting
 - Fishing
 - Hunting/Shooting
 - Landscaping/Gardening
 - Musical instrument
 - Photography

- Pilot
- Sewing
- Video Games
- Woodwork
- Other: _____

- SPORTS**
- Biking
 - Golf
 - Running
 - Scuba-diving
 - Skiing
 - Swimming
 - Tennis
 - Other: _____

2. Are your eyes bothered by glare from any of the following situations:

- | | | |
|---|--|---|
| <input type="checkbox"/> Car headlights | <input type="checkbox"/> Haze | <input type="checkbox"/> Sunshine |
| <input type="checkbox"/> Computer monitor | <input type="checkbox"/> Night driving | <input type="checkbox"/> Traffic lights |
| <input type="checkbox"/> Fluorescent lights | <input type="checkbox"/> Snow | <input type="checkbox"/> Other: _____ |

3. What do you like about your current glasses or contacts?

- | | | | |
|---------------------------------------|----------------------------------|---------------------------------------|------------------------------|
| GLASSES | <input type="checkbox"/> Color | CONTACTS | <input type="checkbox"/> Fit |
| <input type="checkbox"/> Style | <input type="checkbox"/> Comfort | <input type="checkbox"/> Other: _____ | |
| <input type="checkbox"/> Lens | | | |
| <input type="checkbox"/> Fit | | | |
| <input type="checkbox"/> Brand | | | |
| <input type="checkbox"/> Other: _____ | | | |

4. What don't you like about your current glasses or contacts?

- | | | | |
|---------------------------------------|------------------------------------|---------------------------------------|----------------------------------|
| GLASSES | <input type="checkbox"/> Thickness | CONTACTS | <input type="checkbox"/> Dryness |
| <input type="checkbox"/> Glare | <input type="checkbox"/> Comfort | <input type="checkbox"/> Other: _____ | |
| <input type="checkbox"/> Weight | | | |
| <input type="checkbox"/> Other: _____ | | | |



NAME: _____

Privacy Policy

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for services, and to conduct healthcare operations involving our office. The Privacy Policy describes these uses and disclosures in detail. **I acknowledge that I have been offered and/or received a copy of the Privacy Policy from Queen Anne Vision Clinic.**

SIGNATURE _____ DATE _____

Financial Disclaimer

Eligibility for medical insurance and/or routine vision benefits

We will attempt to verify your plan eligibility for services and/or materials before your appointment. *Verification of eligibility is done as a courtesy only and is not a guarantee of payment.* Please check with your plan administrator if you have any questions regarding your eligibility. Queen Anne Vision Clinic participates in select HMO plans.

Liability

I understand that account balances and co-payments are due at time of service. If I have medical insurance or routine vision benefits, I authorize my plan carrier to pay Queen Anne Vision Clinic directly. I authorize Queen Anne Vision Clinic to release any information required for payment to be made. *If my plan carrier does not pay, or partially pays, I understand I am responsible for payment in full for the remaining balance.* My signature below verifies that I understand the above financial disclaimers.

SIGNATURE _____ DATE _____

Contact Lens Fitting Fees

Contact lens patients require additional diagnostic services every year, which are **not included in the annual eye health evaluation.** The additional fee associated with the contact lens fitting is particular to each patients needs. The fee covers any visits related to contact lens care and any fitting changes for 90 days. After the 90 days, there will be an additional cost for any fitting changes, which will be half of what your original fitting fee was. For first time contact lens wearers, there is a teaching fee along with the contact lens fitting fee. **My signature below verifies that I would like to have a contact lens fitting.**

SIGNATURE _____ DATE _____

Digital Retinal Imaging

During your comprehensive exam we will be performing Digital Retinal Imaging (DRI). This technology involves capturing a high-resolution digital image of the interior portion of your eye. This provides us with a digital retinal fingerprint and serves as a baseline for eye-health comparison on future visits. It's the gold standard for preventative care and disease management. The fee for the Digital Retinal Imaging is **\$39.00** and is **not covered by insurance.** If you opt to not do the Digital retinal imaging, we will have to Dilate your eyes. Dilation drops can cause blurred vision, sensitivity to light, and can last anywhere from 2-4 hours, depending on the person. Please initial below whether you would like to do the Digital Retinal Imaging or the Dilation Drops. Initial on the line.

_____ **I ELECT TO HAVE THE DIGITAL RETINAL IMAGING**
(I understand the doctor may recommend both Digital Retinal Imaging and dilation, depending on each patients specific need)

_____ **I DECLINE THE DIGITAL RETINAL IMAGING AND ELECT TO HAVE A DILATED EXAM**