Welcome to Lander Vision Center, P.C.

Thank you for choosing us for your eyecare needs. We are delighted to have you as a patient and appreciate the confidence you placed in us. Please take a moment to complete the following information. Any information we already have on file will appear on this form. Please review all completed areas to ensure that the information we have is current and accurate. If you have any questions, please do not hesitate to ask.

☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms. ☒ Master ☐ Male ☒ Female

First Name | MI | Last Name | Date of Birth | Social Security Number

Mailing Address | City | State Zip | **Email Address**

Home Phone | Day Phone | **Cell Phone** | Spouse or Parent(s) Name | Person Responsible for Account

Patient Status ☐ Single ☐ Married ☐ Other

☐ Full Time Student ☐ Part Time Student ☐ Employed

Family Doctor (PCP) | PCP Phone

Employer Name If Applicable | **Employer Phone** | Emergency Contact | Contact Phone

How were you refered to our office?

☐ Phone Book ☐ School ☐ Advertisement ☒ Patient (Please Name) _____

☐ Insurance Listing ☐ Drive by ☐ Other _____ ☒ Doctor (Please Name) _____

Insurance Information

Patient Relationship to Insured

☐ Self ☐ Spouse ☐ Child ☐ Other

Financial Responsibility

By signing this statement I understand that Lander Vision will bill my insurance I provided on my behalf at the time of service. I understand that if no information is given, I may be responsible to file insurance on my behalf. If Lander Vision Center bills after the date of service I understand there is a billing fee of $25.00. All copays, coinsurance, deductibles, and non-covered services will be due at the time of service. Lander Vision has my permission to accept the payment directly for services/goods provided. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and I am responsible for all balances due. **If your account goes into collections you will be charged 30% collection fee and 18% interest**.

Medicare/Medicaid Patients

Medicare, Medicaid for individuals over 20, and some commerical payers do not cover the refraction portion of an eye health examination. This is the portion of your exam that your glasses and/or contact lens prescription is updated. By signing below, you understand that you are responsible for this fee if insurance does not cover.

Authorization to Release Medical Information

I authorize Lander Vision to release/request medical information on my behalf to/from any entity to assist in my medical care per my request. This assignment will remain in effect until revoked in writing.

Private Health Information

My signature below acknowledges that I was provided the opportunity to receive/review a copy of Lander Vision's Privacy Policy Notice. *A copy of this form will be transferred to an electronic format and will be considered as valid as the original.*

Patient/Guardian Signature_____ Date_____

Name **deletedelete**

Lander Vision Center, P.C.
PATIENT HISTORY AND INFORMATION

Race

- ☐ American Indian Or Alaska Native
- ☐ Asian
- ☐ Black Or African American
- ☐ Hispanic Or Latino
- ☐ Native Hawaiian Or Other Pacific Islander
- ☐ White
- ☐ Declined To Specify

Other Race

Ethnicity ○ Hispanic Or Latino ○ Not Hispanic Or Latino ○ Declined To

Preferred Language ○ English ○ Chinese ○ Dutch; Flemish ○ French ○ German ○ Hindi

Height ft [ ] in [ ] cm/m [ ] ○ ft in ○ cm ○ m **Weight** [ ] ○ lbs ○ kg

PRIMARY CARE PHYSICIAN

Primary Care Physician and Clinic Name

Address of Primary Care Physician City State Zip Phone

REFERRING PHYSICIAN

Referring Physician and Clinic Name

Address of Referring Physician City State Zip Phone

HEALTH HISTORY

What is the main reason for today's exam ? When was your last exam ? Mar 4, 2002

When was your last health exam ?

Past Illnesses or Injuries:

Past Surgeries:

Current Medications:

Current Eye Drops:

Medicines that cause reactions or sensitivities:

Specific Allergies:

EYE HISTORY

Glaucoma	○ Yes ○ No	Dryness	○ Yes ○ No	Strabismus (Crossed Eyes)	○ Yes ○ No
Cataract	○ Yes ○ No	Excess Tearing/Watering	○ Yes ○ No	Blurred Vision Distance	○ Yes ○ No
Macular Degeneration	○ Yes ○ No	Eye Pain or Soreness	○ Yes ○ No	Blurred Vision Near	○ Yes ○ No
Retinal Detachment	○ Yes ○ No	Foreign Body Sensation	○ Yes ○ No	Distorted Vision (halos)	○ Yes ○ No
Color Blindness	○ Yes ○ No	Infection of Eye or Lid	○ Yes ○ No	Double Vision	○ Yes ○ No
Headaches	○ Yes ○ No	Itching	○ Yes ○ No	Floaters or Spots	○ Yes ○ No
Glare/Light Sensitivity	○ Yes ○ No	Mucous Discharge	○ Yes ○ No	Fluctuating Vision	○ Yes ○ No
Tired Eyes	○ Yes ○ No	Drooping Eyelid	○ Yes ○ No	Loss of Vision	○ Yes ○ No
Amblyopia (Lazy Eye)	○ Yes ○ No	Redness	○ Yes ○ No	Loss of Side Vision	○ Yes ○ No
Burning	○ Yes ○ No	Sandy or Gritty Feeling	○ Yes ○ No		

GENERAL HEALTH CONDITION

Fever	O Yes	O No	Respiratory (Asthma)	O Yes	O No	Anxiety or Depression	O Yes	O No
Weight Loss	O Yes	O No	Gastrointestinal	O Yes	O No	Thyroid, Diabetes	O Yes	O No
Other Symptoms	O Yes	O No	Kidney	O Yes	O No	Blood/Lymph	O Yes	O No
Ears,Nose,Throat	O Yes	O No	Muscles,Bones,Joints	O Yes	O No	Allergic	O Yes	O No
Cardiovascular (high blood pressure etc.)	O Yes	O No	Skin	O Yes	O No	**Pregnant**	O Yes	O No
			Neurological (Multiple Sclerosis)	O Yes	O No	**Nursing**	O Yes	O No

Name **delete delete**

Lander Vision Center, P.C.

MEDICAL HISTORY QUESTIONAIRE

FAMILY HISTORY

Amblyopia (Lazy Eye)	O Yes	O No	Retinal Detachment	O Yes	O No	High Blood Pressure	O Yes	O No
Blindness	O Yes	O No	Strabismus (Eye Turn)	O Yes	O No	Kidney Disease	O Yes	O No
Cataract(s)	O Yes	O No	Arthritis	O Yes	O No	Lupus	O Yes	O No
Color Blindness	O Yes	O No	Cancer	O Yes	O No	Stroke	O Yes	O No
Glaucoma	O Yes	O No	Diabetes	O Yes	O No	Thyroid Disease	O Yes	O No
Macular Degeneration	O Yes	O No	Heart Disease	O Yes	O No	Others	O Yes	O No

SOCIAL HISTORY

Current Occupation : _____ Years _____ Employer _____

SPECTACLE LENS HISTORY

Do you use a computer? O Yes O No How many hours/day? _____ Distance from Computer? _____

Do you drive? O Yes O No Mileage to work each way? _____

Do you have glare problems? O Yes O No

Do you have visual difficulty when driving? O Yes O No

Do you have problems with night vision? O Yes O No

Do you currently wear glasses ? O Yes O No Since _____

Type of glasses ☐ FullTime ☐ PartTime ☐ Distance ☐ Close

Glasses Owned ☐ SingleVision ☐ Bifocals ☐ Trifocals ☐ Backup ☐ Safety ☐ Sports ☐ Progressive

Have you had trouble in the past with glasses? O Yes O No _____

Do you wear sunglasses? O Yes O No Are your sun glasses your current prescription ? O Yes O No

SPECIAL EYEWEAR NEEDS

☐ **Computer (special prescriptions, special anti-glare tints or coatings)**
☐ **Occupational (mechanics, plumbers, pilots)**
☐ **Safety Glasses (gardening, woodworking, welding)**
☐ **Sports/Hobbies (racquet sports, motorcycle)**

CONTACT LENS HISTORY

If not a contact lens wearer, are you interested in trying contact lenses at this time ? O Yes O No

Have you ever tried to wear contact lenses? O Yes O No Reason for stopping? _____

Do you currently wear contact lenses? O Yes O No Since _____

Type and brand of contact lenses _____ Today's wearing time ? _____

How many hours/day ? _____ How many days/week ? _____

Please rate the following on a scale of 1-10, with 1 being POOR to 10 being EXCELLENT

	Right	Left		Right	Left		Right	Left
Lens Comfort	_____	_____	Distance Vision	_____	_____	Near Vision	_____	_____

What Solutions do you use? Cleaner _____ Disinfectant _____ Enzyme _____

Name **deletedelete**

Lander Vision Center, P.C.

SOCIAL HISTORY

Do you use nutritional supplements (vitamins etc.)? ○ Yes ○ No

Do you engage in regular exercise? ○ Yes ○ No

Do you drink alcohol ? If yes, how much/often : ○ No ○ Occasional ○ 1 Per Day ○ 2-3/day ○ 4+/day

Do you smoke ? If yes, how much/often : ○ No ○ Occasional ○ 1/2 pack/day ○ 1 pack/day ○ 1+ pack

Smoking Status _____

Method of Tobacco Intake : ○ Smoking ○ Chewing

Do you use Illegal Drugs : ○ Yes ○ No

Hobbies/ Interests : _____