NEW OR EXISTING PATIENT

Date:_____

Patient ID: _____ ❒ Vision Exam ❒ Danny Adams, OD

Check In time: _____ ❒ Medical Exam

Emp. Initials: _____

PATIENT INFORMATION

Patient's Last Name	First (legal name)	Middle Init.	☐ Dr. ☐ Ms. ☐ Mr. ☐ Mrs.	Marital Status (for billing purposes) ☐ Sgl ☐ Mar ☐ Div ☐ Wid

Nickname	Date of Birth (m/d/yy)	☐ Male ☐ Female	Social Security (for billing purposes)	Person with Financial Responsibility

Mailing Address	City	State	Zip

Cell Phone	Day Phone	E-Mail Address	Employer/Occupation

PATIENT HISTORY

#1 Do you have problems with:

- ☐ Redness, itching, tearing, burning, or dryness
- ☐ Routine headaches, double vision, or sudden vision loss
- ☐ Floaters or light flashes
- ☐ Blurriness or eye discomfort

Have you worn glasses before? ☐ Yes ☐ No

Have you worn contacts Before? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No

#2 Have you ever had problems with the following:

- ☐ Allergies
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood/ Cholesterol
- ☐ Cancer
- ☐ Diabetes
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Immune/ Lymphatic
- ☐ Kidney Problems
- ☐ Mental State/ Neurologic
- ☐ Skin/ Integumentary
- ☐ Stomach/ Intestinal
- ☐ Thyroid
- ☐ Eye Disease, Surgery or Injury
- ☐ Pregnant Now

#3 List ANY Medications you take, including over-the-counter medicines.

☐ None

Allergies to Medication? ☐ Yes ⇒ ☐ No

#4 List any disease that tends to run in your family.

☐ None

Last Eye Exam – when/where?	Primary Care Physician.	How did you hear about us?	Sports/Hobbies.

Thank you for filling out this form!

For Office Use

Vitals: BP _____ / _____ Pulse _____

Height _____ Weight _____

VA:

Blue Light Transitions Polarized Anti-Fatigue

PAL BIF TRI Computer DVO / NVO

- ❒ Coding
- ❒ Fee Slip
- ❒ Chart Done
- ❒ Letter to Primary MD/ Refer

- ❒ 92499
- ❒ 92285
- ❒ 92015
- ❒ 92145
- ❒ 76514
- ❒ 92133
- ❒ 92081
- ❒ 992____
- ❒ 92250
- ❒ 92310 ___
- ❒ 66984 ___
- ❒ 66821 ___
- ❒ 67800
- ❒ 92134
- ❒ 92137
- ❒ 92083
- ❒ 920____

Recall, 12 mo.

Tests today: DFE Optos

OCT Mac / Ang / ONH / WS Lipiscan

VF Screen 30-2 / 24-2 /10-2 Pachy

RTC:

Reason RTC: Full DES/MGD Cornea

Cataract Macula Glaucoma Retina

CL Check /Order trials/ Call to Finalize

Tests next visit: DFE Optos IOP

VF Screen / 24-2 / 30-2 / 10-2 Pachy

OCT Mac / Ang / ONH / WS Lipiscan