

Spyglass VISION CLINIC - Welcome To Our Office

Welcome to Spyglass Vision Clinic. Thank you for choosing us for your eye care 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. Dr. Male Female

First Name MI Last Name Preferred Name

Street Address City State ZIP

Social Security # Date of Birth Home Phone (include area code) Work Phone

Email address Spouse or Parent(s) name Person Responsible for Account

Emergency Contact Emergency Phone

How were you referred to our office?

Phone Book School Advertisement Insurance Listing Patient (please name) _____
 Drive By Doctor (please name) _____ Other _____

PRIMARY INSURANCE INFORMATION

Name and Address of Primary Insurance Company City State ZIP

Insured's First Name MI Insured's Last Name Male Female

Insured's Identification # Group # Insured's Date of Birth

Patient Relationship To Insured Self Spouse Child Other
Patient Status Single Married Other
 Full Time Student Part Time Student Employed

SECONDARY INSURANCE INFORMATION

Name and Address of Secondary Insurance Company City State ZIP

Insured's First Name MI Insured's Last Name Male Female

Patient Relationship To Insured Self Spouse Child Other
Insured's Identification # Group # Insured's Date of Birth

Please Read:

In order to control the cost of billing, we ask that the patient's portion is paid at the time services are rendered unless other arrangements are made in advance. We would rather control billing costs than be forced to raise our fees. All professional services and material are charged to the patient. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Accounts 90 days old are subject to collection fees. There will be a service charge on all returned checks.

Payment from my insurance is to be paid directly to Spyglass Vision Clinic. I understand that the insurance company indicated above will be billed as my primary insurance. I understand that billing any secondary insurance is my responsibility. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed. I also acknowledge that I received a copy of Jeffrey A. Young, O.D.'s Notice of Privacy Practices.

Signature Date

Spyglass VISION CLINIC – Patient History and Information

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? _____

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

GENERAL HEALTH CONDITION

Fever	<input type="radio"/> Yes <input type="radio"/> No	Respiratory (Asthma)	<input type="radio"/> Yes <input type="radio"/> No	Anxiety or Depression	<input type="radio"/> Yes <input type="radio"/> No
Weight Loss	<input type="radio"/> Yes <input type="radio"/> No	Gastrointestinal	<input type="radio"/> Yes <input type="radio"/> No	Endocrine (diab, thyroid)	<input type="radio"/> Yes <input type="radio"/> No
Other Symptoms	<input type="radio"/> Yes <input type="radio"/> No	Kidney	<input type="radio"/> Yes <input type="radio"/> No	Blood/Lymph	<input type="radio"/> Yes <input type="radio"/> No
Ears, Nose, Throat	<input type="radio"/> Yes <input type="radio"/> No	Muscles, Bones, Joints	<input type="radio"/> Yes <input type="radio"/> No	Allergic	<input type="radio"/> Yes <input type="radio"/> No
Cardiovascular	<input type="radio"/> Yes <input type="radio"/> No	Skin	<input type="radio"/> Yes <input type="radio"/> No	Are you pregnant ?	<input type="radio"/> Yes <input type="radio"/> No
(high blood pressure, heart, etc)		Neurological (M.S., etc)	<input type="radio"/> Yes <input type="radio"/> No	Are you nursing ?	<input type="radio"/> Yes <input type="radio"/> No

FAMILY HISTORY

Amblyopia (Lazy Eye)	<input type="radio"/> Yes <input type="radio"/> No	Retinal Detachment	<input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No
Blindness	<input type="radio"/> Yes <input type="radio"/> No	Strabismus (Eye Turn)	<input type="radio"/> Yes <input type="radio"/> No	Kidney Disease	<input type="radio"/> Yes <input type="radio"/> No
Cataract	<input type="radio"/> Yes <input type="radio"/> No	Arthritis	<input type="radio"/> Yes <input type="radio"/> No	Lupus	<input type="radio"/> Yes <input type="radio"/> No
Color Blindness	<input type="radio"/> Yes <input type="radio"/> No	Cancer	<input type="radio"/> Yes <input type="radio"/> No	Stroke	<input type="radio"/> Yes <input type="radio"/> No
Glaucoma	<input type="radio"/> Yes <input type="radio"/> No	Diabetes	<input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease	<input type="radio"/> Yes <input type="radio"/> No
Macular Degeneration	<input type="radio"/> Yes <input type="radio"/> No	Heart Disease	<input type="radio"/> Yes <input type="radio"/> No	Others	<input type="radio"/> Yes <input type="radio"/> No

Spyglass VISION CLINIC – Questionnaire

Current Occupation: _____ Years _____ Employer _____

SPECTACLE LENS HISTORY

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

Do you drive? Yes No Mileage to work each way? _____ Do you have glare problems? Yes No

Do you have difficulty when driving? Yes No

Do you have problems with night vision? Yes No

Do you currently wear glasses? Yes No Since _____

How often? Full Time Part Time Distance Only Near Only

Glasses owned:

Single Vision Bifocals Trifocals Back-up Glasses Safety Glasses Sports Glasses Progressives

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

Do you wear sunglasses? Yes No Are your sunglasses your current prescription? Yes No

SPECIAL EYEWEAR NEEDS

Computer (special prescriptions, anti-glare tints or coatings) Safety Glasses (gardening, woodworking, welding)

Occupational (mechanics, plumbers, pilots) Sports/Hobbies (racquet sports, motorcycle)

CONTACT LENS HISTORY

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

Do you currently wear contact lenses? Yes No Since _____

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

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

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

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

What Solutions do you use? _____

SOCIAL HISTORY

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

Do you engage in regular exercise? Yes No

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

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

Method of Tobacco Intake: Smoking Chewing

Do you use Illegal Drugs? Yes No

Hobbies / Interests: _____

**PLEASE FAX COMPLETED FORM TO (360) 312-5471
or bring with you to your appointment**