

Patient Information

Today's Date
Last
First MI
Street
City State
Zip Code
Home Phone
Cell Phone
Email
Employer (or School)
Occupation (or Grade)
Date of Birth SSN
Sex M F
What is the purpose of this visit? Glasses/ Contacts/ other?
Are you experiencing any problems with your current contact lenses or glasses?

Have you ever experienced, been diagnosed or treated for any of the following?

- Blurry Vision
Cataracts
Crossed eye/Eye turn
Eye Infections
Flash of light
Glaucoma
Headaches
Itchiness
Macular Degeneration
Retinal Detachment
Tearing
Uncomfortable glasses
Squinting
Other eye disorders
Burning
Corneal Abrasions
Double Vision
Eye Injury
Floaters/Spots
Gritty eyes
Iritis/Uveitis
Lazy Eye
Occasional dryness
Sunlight Sensitivity
Trouble at night
Eye Fatigue/Strain

Have you had any injuries or surgeries in your eyes? Yes No

If yes, What / Which eye/ When?

Insurance Information

Please note that insurance does NOT cover the Contact Lens Evaluation and related follow up visits.

Vision Insurance
Sponsor Name
Sponsor SSN
Sponsor Address if different from patient address:
Street
City State
Zip Code

Advance Beneficiary Notice: Please be advised if you are using insurance coverage for today's visit, this is a contract between you and your insurance company. If your insurance company has not reimbursed our office in full within 60 days, you will be billed for your services. In the event that you do not make a reasonable effort to make payments, your account will be sent to a collection agency, and you will be charged a \$90 collection fee.

Patient Name:

Signature (Patient/Guardian)

Date:

Acknowledgement of Receipt of Notice of Privacy Policy:

Please be advised that a copy of our HIPAA policy is posted in our office and is available by photocopy to all our patients. Please ask our staff if you would like to receive a copy of our Privacy Policy today. By signing below, I acknowledge that I have been made available a copy of Dr. Chinn's Notice of Privacy Policy.

Patient Name:

Signature (Patient/Guardian)

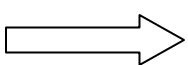
Date:

OFFICE POLICY:

You have 90 days following your Comprehensive Eye Exam to return for any glasses related follow-up visits at no charge. After 90 days, you will be charged \$45 for a glasses refraction if there are any problems with your glasses. A Comprehensive Eye Examination is required after 12 months from your initial visit. The fee for this exam without insurance is \$85. Please note that there is no refund on spectacle purchases after the prescription lenses has been made.

(initials) (Patient/Guardian)

OVER PLEASE



The information in this confidential case history form is critical to the evaluation of your vision and health.

Medical History

Name of Family Physician _____

City/ State _____

Date of Last Eye Exam _____

By Whom? _____ Dilated? Yes No

CURRENT MEDICATIONS (Rx or Over the Counter)

(List name of medications including eye drops, vitamins, & birth control pills) _____

Allergies to medications? Yes No

If so, what medications? _____

Do you use cigarettes/tobacco, alcohol, or other substances? Yes No

Women: Are you pregnant or nursing? Yes No

Have you ever been diagnosed or treated for the following health problems?

- | | |
|--|--|
| <input type="checkbox"/> Allergies (non-medication): _____ | <input type="checkbox"/> Arthritis: Duration _____ |
| <input type="checkbox"/> Blood/Lymph: Duration _____ | <input type="checkbox"/> Bronchitis: Duration _____ |
| <input type="checkbox"/> Cancer: Type/Duration _____ | <input type="checkbox"/> High Cholesterol: Duration _____ |
| <input type="checkbox"/> Diabetes: Type/Duration _____ | <input type="checkbox"/> Digestive: Duration _____ |
| <input type="checkbox"/> Ears/Nose/Throat: Duration _____ | <input type="checkbox"/> Endocrine (thyroid): Duration _____ |
| <input type="checkbox"/> Eczema/Rashes: Duration _____ | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Recurrent Fevers: Duration _____ | <input type="checkbox"/> Genitourinary |
| <input type="checkbox"/> High Blood Pressure: Duration _____ | <input type="checkbox"/> Integumentary (Skin) |
| <input type="checkbox"/> Kidney: Duration _____ | <input type="checkbox"/> Muscle/Bone : Duration _____ |
| <input type="checkbox"/> Neurological: Duration _____ | <input type="checkbox"/> Psychological: Type _____ |
| <input type="checkbox"/> Respiratory: Duration _____ | <input type="checkbox"/> Sinus |
| <input type="checkbox"/> Throat Infections: Duration _____ | <input type="checkbox"/> Thyroid: Duration _____ |
| <input type="checkbox"/> Unusual weight losses/gains | <input type="checkbox"/> Developmental/learning delay: _____ |

Is there a family medical history of any of the following: Relationship to you /(on Mother/ Father side)

- | | | |
|----------------------|--------------------------|-------|
| Retinal Problems | <input type="checkbox"/> | _____ |
| Macular Degeneration | <input type="checkbox"/> | _____ |
| Lazy Eye | <input type="checkbox"/> | _____ |
| Heart Disease | <input type="checkbox"/> | _____ |
| Hypertension | <input type="checkbox"/> | _____ |

- | | | |
|------------------|--------------------------|-------|
| Blindness | <input type="checkbox"/> | _____ |
| Cataracts | <input type="checkbox"/> | _____ |
| Corneal Problems | <input type="checkbox"/> | _____ |
| Diabetes | <input type="checkbox"/> | _____ |
| Glaucoma | <input type="checkbox"/> | _____ |