The Vision Store

WELCOME TO OUR OFFICE

Our Mission

We Are Dedicated To Providing Our Patients With The Highest Quality Eye Care And Service Possible. We Will Seek Continuing Education To Remain At The Forefront Of Our Profession And Will Offer The Latest Eye Care Technology And Products. We Are Committed To Delivering This Care With Honesty And Compassion To Better Serve You And Your Family.

Please Complete ALL Sections

Patient Information

Today's Date_____
Last _____
First _____MI _____
Street _____
City _____ State _____
Zip Code _____
Phone Home _____Cell_____
Work Phone _____
Patient's SSN _____
Date of Birth _____Age _____
Sex M F
Email Address _____
Employer (or School) _____
Driver's License _____State_____
Occupation (or Grade) _____
Guarantor (or Parent's Name) _____
Guarantor (Employer) _____
Guarantor's Address_____
City_____State_____Zip_____
Sex_____ DOB _____ SSN
_____

What is the purpose of this visit? Are you experiencing any problems with your current contact lenses or eyeglasses?_____
_____
❑CC

Insurance Information

Vision Insurance_____
Relation to
Subscriber_____
Subscriber SSN _____
Subscriber Birth Date _____
Insurance ID_____
Policy Group #_____

Primary Medical Insurance _____
Subscriber Name _____
Subscriber SSN _____
Subscriber Birth Date
_____
Insurance ID
_____

Lifestyle Questions

Do you…… (Check box if your answer is yes)
❑..Work at a computer? Hrs. /Day___cell phone___
flat screen tv___ tablet/I pad_____
❑..Think you might benefit from thinner, lighter lenses?
❑..Have interest in a "test drive" of the latest contact lens designs
❑..Spend time outdoors? How much? _____Hrs/week
❑..Have polarized prescription sun wear?
❑..Prefer not to wear your glasses at times?
❑..Want information on Laser Vision Correction surgery?
❑..Have more than 1 pair of current Rx eyewear?
❑..Have children?
❑..Have family members in need of eye care?
❑..What do you do for fun?

WHO MAY WE THANK FOR REFERRING YOU?
__Yellow Pages __Social media __Internet / website
__Walk in __Drive by __Insurance
*__Family/Friend Name:*_____

Do you experience or have you been diagnosed or treated for any of the following?

❑ Blurry Vision
❑ Cataracts
❑ Crossed eye/Eye turn
❑ Eye Infections
❑ Flash of light
❑ Glaucoma
❑ Headaches
❑ Lazy Eye
❑ Macular Degeneration
❑ Retinal Detachment
❑ Floaters
❑ Uncomfortable glasses
❑ Iritis/Uveitis
❑ Corneal Abrasion
❑ Double Vision
❑ Eye Injury
❑ Tearing
❑ Grittiness
❑ Burning
❑ Itchiness/Allergies
❑ Dry Eyes
❑ Sunlight Sensitivity
❑ Trouble seeing at night

❑CC

Patient Eye History

Date of Last Eye Exam: _____
By Whom? _____
Please note that some insurance do NOT cover the Contact Lens Fitting Evaluation.
Are you interested in contact lenses? q Yes q No
Do you currently wear contact lenses? q Yes q No
What brand of Contacts? _____
Solution used?_____
Are you satisfied with the vision and comfort of your contact lenses? q Yes q No
Would you prefer clear contact lenses or colored contact lenses? q Clear q Colored
If you wear bifocals? Do the lines or head tilting bother you?
q Yes q No

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

Patient Medical History

Name of Family Physician_____ ☐ RFV
Town_____
Date of Last Physical Check-up_____
CURRENT MEDICATIONS (Rx or Over the Counter)
(List name of medications including eye drops, vitamins, & birth control pills)
☐PH
_____
_____

Are you allergic to any medications? q Yes q No
If so, which medications?
_____
_____

Have you had any surgeries? q Yes q No
Please List _____

Do you use cigarettes/tobacco, alcohol, or other substances? qYes q No ☐ PH

Are you Pregnant? q No q Yes Months? _____

Have you ever been diagnosed or treated for any of following health problems?
(Check all that apply to you. Y –yes N- no)

Constitutional
_Developmental disability
_Weight Loss
_Fever
_Fatigue
_Migraines
_Excessive Headaches
Skin/Integumentary
_Eczema
_Skin Cancer
_Psoriasis
Cardiovascular
_Heart Disease
_Stroke
_Vascular Disease
_Hypertension
Respiratory
_Asthma
_Bronchitis
_Emphysema
Neurological
_Multiple Sclerosis
_Epilepsy
Endocrine
_Diabetes
_Thyroid Problems
Ears/Nose/Throat
_Hearing Problems
_Upper Respiratory tract infection

Gastrointestinal
_Ulcer
_Colitis
_Digestive Disorder
Genitourinary
_Urinary Tract infections
_Kidney Problems
_STD
Musculoskeletal
_Fibromyalgia
_Osteoarthritis
_Muscular Dystrophy
_Arthritis
Psychiatric
_Depression
_Panic Disorder
_Schizophrenia
Hematologic/Lymphatic
_Anemia
_Leukemia
_Clotting Disorder
Allergic/Immunologic
_Drug Allergy
_Hay Fever
_Lupus
_ Aids

Other: _____

☐ PH/ROS

Family Medical/Eye History (Check all that apply)

Is there a family medical history of any of the following? ☐ PH
(Please indicate relationship and Mother or Father's side.)

Blindness ❑_____
Cataracts ❑_____
Corneal Problems ❑_____
Diabetes ❑_____
Glaucoma ❑_____
Heart Disease ❑_____
Lazy Eye ❑_____
Macular Degeneration ❑_____
Retinal Problems ❑_____

- The **Visual Field Screening** is a highly sophisticated computer screening test that measures the sensitivity of the retina and also the central and peripheral vision for areas of loss of sight. Visual field testing can assist in early detection of glaucoma, retinal problems and some neurological problems such as brain tumors and optic diseases. This is NOT the air puff glaucoma screening test which is included in the routine exam. We are committed to the prevention of eye diseases as well as early detection. We strongly recommend that all of our patients receive this test as part of our comprehensive visual analysis. The fee for this screening test is **$20.00.** It is possible that additional, more comprehensive visual field testing may be necessary based on the result of your visual field screening or the visual analysis by the doctor. (***Medicare and most other insurance companies do not cover screening.)***

____I choose to have this test____I choose not to have this test

- We recommend the **Optomap Retinal Screening** technology which helps the doctor obtain an in depth view of the internal ocular structures in order to detect problems such as glaucoma, cataracts, retinal detachment, macular degeneration, diabetes and high blood pressure, often before there are any obvious symptoms. The fee for this screening test is **$39.00**.
- If you choose not to have Optomap then your eyes will be dilated. Dilating the pupils have moderate to severe side effects, some people may experience blurred vision mainly at near and sensitivity to light for two to three hours after the examination. Sunglasses are necessary for outdoors after this procedure.
- The treatment recommended by our office is never based on what your insurance company will pay but what your specific needs are. Your treatment should not be governed by your insurance contract. However, it should be understood, that the insurance contract is between the insurance company and the patient, who bears the ultimate financial responsibility. If the insurance company fails to pay within 60 days after claim submission, the balance due will be transferred to the patient or guarantor.

Patient portion, including Contact Lens Fitting and Co pays, are due the same day treatment is rendered. Professional fees are nonrefundable. This is an agreement in which you, the patient or legal guardian, agree to pay for professional services and ophthalmic products, rendered by Dr. Deidra M. Casaus and The Vision Store.
It is agreed that if in the event of legal proceeding to collect any part of fees due, the patient or legal guardian agrees to pay additional sum including attorney fees and collection costs.

- ***I have read and understand the notice of Privacy disclosed in the HIPPA Form and the information stated above.***

Signature _____Date _____

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