The Vision Store

WELCOME BACK TO OUR OFFICE

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

Today's Date_____

Last _____
First _____MI _____
Street _____
City _____ State _____
Zip Code _____
Phone Home _____Cell_____
Work Phone _____

Email address_____
Appointment Time and Date: _____
May we contact you via text and email regarding important information? Yes_____ No_____
What is the purpose of this visit? Are you experiencing any problems with your current contact lenses or eyeglass?_____
_____ **c**
Check all that apply Computer use hr/day_____ smart phone___tablet/ipad____flat screen TV____
☐ CC

Patient Eye History

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 Abrasions
_ Double Vision
_ Eye Injury
_ Tearing
_ Grittiness
_ Burning
_ Itchiness/Allergies
_ Dry Eyes
_ Sunlight Sensitivity
_ Trouble seeing at night
_ other eye disorders: _____☐ CC

Please note that insurance may NOT cover the Contact Lens Fitting Evaluation.
Are you interested in contact lenses? ☐ Yes ☐ No
Do you currently wear contact lenses? ☐ Yes ☐ No
What brand? _____
Solutions used:_____
Are you satisfied with the vision and comfort of your contact lenses? ☐ Yes ☐ No
If you wear bifocals, do the lines bother you?
☐ Yes ☐ No
__

Please Update Medication List and Medical History

Name of Family Physician : _____☐ RFV
Address/City/State: _____
Date of Last Physical Check-up: _____
CURRENT MEDICATIONS (Rx and Over the Counter)
(List name of medications including eye drops, vitamins, & birth control pills)_____☐PH
_____
Are you allergic to any medications? ☐ Yes ☐ No
If so, what medications? _____
_____
Have you had any surgeries? ☐ Yes ☐ No
Please List _____
Do you use cigarettes/tobacco, alcohol, or other substances? ☐Yes ☐ No
Are you Pregnant? ☐ No ☐ Yes Months? _____
Have you ever been diagnosed or treated for any of following health problems?
(Check all. 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
_Thyrroid
Ears/Nose/Throat
_Hearing Problems
_Upper respiratory tract infection
Gastrointestinal
_Ulcer
_Colitis
_Digestive Disorder

Genitourinary
_Urinary tract infection
_Kidney Problems
_STD
Musculoskeletal
_Fibromyalgia
_Osteoarthritis
_Muscular Dystrophy
_Arthritis
Psychiatric
_Depression
_Panic Disorder
_Schizophrenia
Hematologic/Lymphatic
_Anemia
_Leukemia
_Clotting Disorder
Allergy/Immunologic
_Drug Allergy
_Hay Fever
_Lupus
_Aids

Other_____
_____
_____
_____
_____
_____

☐PH/ROS

Please update family medical/eye history

Is there a family 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 ❑_____

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.

- A contact lens prescription is not the same as a prescription for glasses. Contact lenses are considered Class III Medical Devices by the FDA, which means that they require the highest degree of control due to the potential for complications. Contact lenses cannot be dispensed without additional measurements and evaluation of the lenses on the eyes. The fees for contact lens treatment and medical management are not covered under a routine eye examination. Contact lens exams are highly recommended on an annual basis. The contact lens prescription is good for one year due to valid clinical reasons of maintaining good ocular health and potential prescription changes. Dr Casaus follows the American Optometric Association guidelines for all areas of eye care including contact lenses. It is imperative that you adhere to the wearing schedule and solution regimen prescribed by Dr. Casaus. Once a contact lens prescription is finalized, it is available for a specified number of refills at the Dr's discretion. All associated fees must be paid prior to the dispensing of contact lenses and/or contact lens prescription release. We do not guarantee that every patient who wants to wear contact lenses will be successful with them. If a patient tries contact lenses and decides not to proceed with them, they are not required to purchase contact lenses. The contact lens treatment and medical management fees are non-refundable.
- 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 vision 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 the 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 any legal proceedings to collect any part of this agreement, the patient or legal guardian agrees to pay additional sums 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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