Family Vision Center
PO Box 220
Carrington, ND 58421

WELCOME TO OUR OFFICE

Patient Information

Today's Date____________________________________

Last Name_______________________________________
First_________________________________ MI________

Street____
City ____
State_________________ Zip Code__________________

Home Phone _____________________________________
Work Phone______________________________________
Cell Phone ______________________________________
Preferred Number ❑Home ❑Work ❑Cell

Patient's SSN____________________________________
Employer (or School)_______________________________
Occupation (or Grade) ______________________________

Spouse's (or Parent's) Name_________________________
Spouse's (or Parent's) Work _________________________
Person to Contact in Case of Emergency ______________
____

Date of Birth______________________Age___________
Sex ❑M ❑F
Email Address ___________________________________

What is the major purpose of this visit?________________
____
Any problems with your current contact lenses or glasses? _______________________________________
____

VERY IMPORTANT! NEW PATIENTS ONLY:
Who may we thank for referring you to our office?
Name of friend or relative ______________________
If not referred, how did you choose our office?
❑ Another Dr.
❑ Insurance List
❑ Saw Sign/Building
❑ Newspaper/Radio/TV
❑ Yellow Pages: Which directory? ______________

Insurance Information

Please note that insurance does NOT cover the Contact Lens Follow-Up Evaluation.

Vision Insurance:____________________________________

Insurance Number____________________________________

Subscriber Name____________________ BirthDate________

Primary Medical Insurance:_____________________________

Insurance Number____________________________________

Subscriber Name____________________ BirthDate________

Secondary Medical Insurance:___________________________

Insurance Number____________________________________

Subscriber Name____________________ BirthDate________

Lifestyle Questions

Do you……(check box if your answer is yes)
❑..work at a computer?
❑..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 prescription sunwear?
❑..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 eyecare?

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
❑ Other eye disorders___________________________
❑ Burning
❑ Corneal Abrasions
❑ Double Vision
❑ Eye Injury
❑ Floaters/Spots
❑ Grittiness
❑ Iritis/Uveitis
❑ Lazy Eye
❑ Occasional dryness
❑ Sunlight Sensitivity
❑ Trouble seeing at night

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

Patient Medical History

Name of Family Physician ______________________________
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:______________________________

Allergies to medications? ❑ Yes ❑ No
If so, what medications?______________________________
Have you had any surgeries? ❑ Yes ❑ No
Do you use cigarettes/tobacco, alcohol, or other substances? ❑ Yes ❑ No

Have you ever been diagnosed or treated for the following health problems?	**Yes**	**No**
Allergies	❑	❑
Arthritis	❑	❑
Blood/Lymph	❑	❑
Bronchitis	❑	❑
Cancer	❑	❑
Cholesterol	❑	❑
Diabetes	❑	❑
Digestive	❑	❑
Ears/Nose/Throat	❑	❑
Endocrine	❑	❑
Eczema/Rashes	❑	❑
Fatigue	❑	❑
Fevers	❑	❑
Genitourinary	❑	❑
High Blood Pressure	❑	❑
Integumentary (Skin)	❑	❑
Kidney	❑	❑
Muscle/Bone	❑	❑
Neurological	❑	❑
Psychological	❑	❑
Respiratory	❑	❑
Sinus	❑	❑
Throat Infections	❑	❑
Thyroid	❑	❑
Unusual weight losses/gains	❑	❑

Patient Eye History

Date of Last Eye Exam______________________________
By Whom?______________________________

Have you ever tried contact lenses? ❑ Yes ❑ No
Do you currently wear contact lenses? ❑ Yes ❑ No
What kind?______________________________
Solutions used______________________________

Are you satisfied with the vision and comfort of your contact lenses? ❑ Yes ❑ No
Would you prefer clear contact lenses or colored contact lenses? ❑ Clear ❑ Colored

If wearing bifocals, do the lines or head tilting bother you? ❑ Yes ❑ No

Family Medical/Eye History (Check all that apply)

Is there a family medical history of any of the following:
❑ No ❑ Yes — If Yes, please check boxes and designate relationship (Mother's or Father's side)

Condition		Relationship
Blindness	❑	______________
Cataracts	❑	______________
Corneal Problems	❑	______________
Diabetes	❑	______________
Glaucoma	❑	______________
Heart Disease	❑	______________
Lazy Eye	❑	______________
Macular Degeneration	❑	______________
Retinal Problems	❑	______________

Do you participate in a flex spending account?
❑ Yes ❑ No
What is your payment preference today?
❑ Cash ❑ Check ❑ Credit Card

Our Mission is to provide the highest standard of care to our patients that will enhance their quality of life with a dedication to patient education and technology.