

# Welcome to Hometown Vision Center

(Please Print)

Name \_\_\_\_\_ Today's Date \_\_\_\_\_ When Was Your Last Exam? \_\_\_\_\_  
 Street \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Name of Insurance Holder \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Date of Birth of Insurance Holder \_\_\_\_\_  
 Sex:  M  F Social Security # \_\_\_\_\_ Spouse (or Parents') Name \_\_\_\_\_  
 Employer (or School) \_\_\_\_\_ Spouse (or Parents') Work Phone \_\_\_\_\_  
 Occupation (or Grade) \_\_\_\_\_ Insurance: Vision \_\_\_\_\_ Health \_\_\_\_\_  
 Email Address \_\_\_\_\_

**If new patient, how did you first hear about our office?**

- Referred—by whom? \_\_\_\_\_
- Yellow Pages—Which Directory? \_\_\_\_\_
- Newspaper—Which Paper? \_\_\_\_\_
- Sign \_\_\_\_\_
- Other \_\_\_\_\_

**Are you interested in (Check all that apply)....?**

- New Glasses  Laser Surgery  Invisible Bifocals
- Contacts  Computer Glasses  Spare Glasses
- Sunglasses  UV Protection  Safety Glasses
- Non-Glare Lens  Thin, Light Lenses  Sports Glasses

**Who is your family Doctor?** \_\_\_\_\_

**What is the main reason for your visit today?** \_\_\_\_\_

<u>DO YOU HAVE...</u>			<u>DO ANY OF YOUR BLOOD RELATIVES HAVE....</u>			<u>PLEASE LIST ALL MEDICATIONS YOU ARE TAKING (Including Birth Control or any Non-Prescription Medications):</u>
	YES	NO	YES	NO	<u>RELATIONSHIP</u>	
Diabetes-----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
High Blood Pressure -	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Glaucoma-----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Cataracts -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Arthritis-----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Heart Disease -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Thyroid Disease -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Lazy Eye/Amblyopia -	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Headaches -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Double Vision-----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Asthma-----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Other -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Do you smoke-----	<input type="checkbox"/>	<input type="checkbox"/>				_____
Do you drink alcohol--	<input type="checkbox"/>	<input type="checkbox"/>				_____

**Describe any past eye injuries, head injuries, or eye surgeries** \_\_\_\_\_

.....

## RETINAL EXAM

No eye exam is complete without a full evaluation of the internal health of the eye. This is the only way to ensure the continued health of your eyes, as well as to possibly detect and monitor general health conditions such as diabetes, high blood pressure, etc. We now have an alternative to pupillary dilation...the *Optomap Retinal Exam*. This new technology allows Dr. Wheeler to get a full photographic image of the retina in 1/4 of a second *without* eye drops (in most cases). This also gives us a permanent record of your retinal image to compare year to year. Dr. Wheeler strongly recommends this procedure, as this is the most effective way to evaluate and monitor the retina. Pupillary dilation is sometimes necessary to supplement the Optomap images.

.....

*I accept financial responsibility for any charges incurred. Patient is responsible for insurance deductibles, co-pay, and non-covered items. Patient is responsible for any collection fees on past due accounts*

\_\_\_\_\_  
(Signature of Responsible Party) (Date)

**HOW WILL YOU BE PAYING TODAY?**  Cash  Check  Credit Card