VISION REHABILITATION ASSOCIATES, P.C.

DOCTORS OF OPTOMETRY

Michael Zost, O.D., FCOVD, FAAO
Jennifer Hunsader, O.D.

Date Completed: _____

We are pleased to welcome you to our practice. The following information will aid us in providing the most complete care possible. Please take a few minutes to fill out this form as completely as you can. If you have questions, we will be glad to assist you.

PATIENT INFORMATION

Name _____

Address _____

City _____ State _____ Zip _____

Preferred Phone (Home/ Work / Cell) _____

Alternate Phone (Home/ Work / Cell) _____

Email _____

Preferred Contact Method: ☐ Mail ☐ Phone ☐ Email

Sex ❒ M ❒ F Age _____ Birth date _____

SS# _____

Occupation _____ Employer _____

If a Student, School Name _____ Grade Enrolled in _____

To best monitor for ethnic related health and vision conditions, please check if any apply:

Black or African American	❒	Hispanic	❒
American Indian or Alaska Native	❒	White	❒
Asian, Asian American, or Pacific Islander	❒		

REASON FOR TODAY'S VISIT

Date of last eye exam _____ Eye Doctor's Name _____

Were you referred by a doctor? ❒ Y ❒ N Doctor's name: _____

What brings you here today?

- ❒ Annual Check-up / Not having any problems
- ❒ Challenges with clarity of far or near vision
- ❒ Replace lost or broken spectacles
- ❒ Need back-up spectacles or sunglasses
- ❒ Need more contact lenses or would like to try contact Lenses
- ❒ Trouble using eyes comfortably
- ❒ Other _____

To get a better sense of how you use your eyes, are there any hobbies, sports, or other recreational activities you participate in on a regular basis?

_____

_____

Do you currently wear glasses? ❒ Yes ❒ No ❒ All the time ❒ Occasionally

❒ Distance tasks ❒ Near Tasks ❒ Computer Use ❒ Sunglasses

Do you wear contact lenses? ❒ No ❒ Yes Brand if known _____

Pairs Left _____ Replacement Schedule _____

Hours Worn /Day _____ Solutions used _____

NOTICE OF PRIVACY PRACTICE

I acknowledge that I been offered a copy of Vision Rehabilitation Associates' Notice of Privacy Practices. Signature: _____ Date: _____

ASSIGNMENT OF INSURANCE BENEFITS / PAYMENT GUARANTEE

I hereby authorize payment to be made directly to Vision Rehabilitation Associates, P.C. for vision plan or insurance benefits payable to me for services or materials rendered that I have received from Vision Rehabilitation Associates, P.C. I understand that I am financially responsible to Vision Rehabilitation Associates, P.C. for any non-covered services or materials, as defined by my insurer, which are not paid by my primary or secondary insurer. I also understand that if my account balance becomes overdue and the overdue account is referred to a collection agency, a collection fee will be added to the amount due and that I am financially responsible for the added costs also.

Signature: _____ Date: _____

EYE / VISION CONCERNS

Place a "√" in any ❒ to indicate if you are experiencing any of the following.

❒ Blurred Vision – Distance	❒ Blurred Vision – Near
❒ Burning Eyes	❒ Crossed or Wandering Eye
❒ Crusty Eyelids	❒ Discharge from Eyes
❒ Dizzy Spells / Balance issues	❒ Double Vision
❒ Dry Eyes	❒ Eye Infection or Eye Injury
❒ Eye Strain, Fatigue, or Tiredness	❒ Fluctuating Vision
❒ Headaches	❒ Itching Eyes
❒ Light Sensitivity	❒ Poor Night Vision
❒ Red Eyes	❒ Seeing Flashes or Floaters, Halos or Spots
❒ Temporary Loss of Vision	❒ Twitching Eyelid

Place a "√" in any ❒ to indicate if you or any blood relative has had any of the following problems (including parents, grandparents, uncles, aunts or siblings).

	Yourself	Family Members
Blindness	❒	❒
Cataracts	❒	❒
Eye Surgery	❒	❒
Glaucoma	❒	❒
Lazy Eye or Turned Eye	❒	❒
Macular Degeneration	❒	❒
Retinal Detachment	❒	❒
Vision Training	❒	❒

HEALTH HISTORY

Date of your last physical _____

Primary Care Physician's name _____

Phone number if known _____

Place a "√" in any ❒ to indicate if you or any blood relative has had any of the following problems (including parents, grandparents, uncles, aunts or siblings).

	Yourself	Family Members
Anxiety	❒	❒
Asthma	❒	❒
Cancer	❒	❒
Depression	❒	❒
Diabetes	❒	❒
Head Injury / Stroke	❒	❒
Heart Condition	❒	❒
High Blood Pressure	❒	❒
High Cholesterol	❒	❒
Migraine Headaches	❒	❒
Multiple Sclerosis	❒	❒
Shingles	❒	❒
Thyroid Condition	❒	❒

Other _____

Do you use tobacco? ❒ Yes ❒ No Do you drink alcohol? ❒ Yes ❒ No

Are you pregnant or nursing? [Females Only] ❒ Yes ❒ No

SENSITIVITIES OR ALLERGIES Place a "√" in any ❒ to indicate if you have any in the categories below.

- ❒ Drugs (Please List) _____
- ❒ Foods (Please List) _____
- ❒ Environmental / Seasonal (Please include which season bothers you most) _____

MEDICATIONS / VITAMINS / SUPPLEMENTS

Place a "√" in any ❒ to indicate if you use any prescribed or over-the-counter substances in the categories below.

- ❒ Eye Drops (Please List) _____
- ❒ Medications (Please List) _____
- ❒ Vitamins / Supplements (Please List) _____

— Thank You —