bright eyes VISION CLINIC

ADULT & PEDIATRIC VISION CARE

Welcome to Bright Eyes Vision Clinic
Patient Information

Name:_____ **Birthdate:** _____

Parents/Guardian Names (if minor child): _____

Address: _____

City, State, Zip: _____

Home Phone: (__) _____ **Work:** (__) _____

Cell: (__) _____ **Number best to reach you:** _____

Email address: _____

Marital Status: M S D **Sex:** M F

How did you hear about our office?

Doctor Referral/Name _____

Patient Referral/Name_____

Location Newspaper Internet Yellow pages InfantSEE Other: _____

Social Security Number:
Occupation:
Employer:
School/ Grade:
Do you have VSP (Vision Service Plan)? Yes No

Primary Insurance:
Secondary Insurance:
Primary Insured Name/ Birth Date:
Primary Insured Phone:
Emergency Contact:
Relationship: Phone:

Please be sure you have filled out both sides.

Insurance Authorization, Financial & Privacy Policies

* I understand that if I am diagnosed with/or have symptoms of a medical condition such as: glaucoma, dry eye, double vision, headaches, strabismus, infection, corneal disorders, diabetes, amblyopia, cataracts, blurred vision, eye strain, dizziness, etc., my visit is considered a medical visit and will be billed to my medical insurance. Follow up visits will also be considered as a medical visit and will be billed to my medical insurance. I am aware that a routine/well vision eye exam (nearsighted, farsighted, astigmatism, etc.) will be billed if I have no medical symptoms or medical conditions. I authorize Bright Eyes Vision Clinic to administer diagnostic and medical procedures as may be necessary for proper health care.
* I acknowledge that I received or was given access to a copy of the Notices of Privacy Practices for Bright Eyes Vision Clinic.
* I authorize any holder of medical information about me to be released to my insurance company needed to determine benefits and file claims. I request that insurance payment for any services furnished be made on my behalf to Bright Eyes Vision Clinic, PA. I understand that insurance is a contract between myself and my insurance company. Bright Eyes Vision Clinic cannot guarantee insurance benefits.
* I understand that I am responsible for charges not paid by my insurance plan and providing current insurance information prior to the start of my appointment. Due to most insurance companies providing, unreliable, inconsistent information regarding coverage, Bright Eyes does not check benefit levels prior to the appointment. I understand any remaining balance on my account after 30 days will accrue interest at annual rate of 18% and that I will be responsible for any reasonable costs associated with collection of past-due balances. I am aware that a service charge of $30 will be applied for each NSF or stop payment checks. Bright Eyes Vision Clinic is not a provider for all insurance plans including MHCP(Minnesota Health Care Plans.)
* It is my responsibility to notify Bright Eyes Vision Clinic if I carry VSP insurance before ordering glasses as we may use a non-VSP lab.
*I understand that Bright Eyes Vision Clinic does not allow for returns or exchanges on eye wear.

CONTACT LENS EVALUATION FEES

As a contact lens wearer, additional tests are done for you that are necessary to make sure your eyes are healthy, that your lenses fit properly, and to ensure that you are seeing as well as possible. Contact lens professional fees are for the extra testing and time taken by the staff and doctor each year to properly evaluate your contact lenses and eye health. Contact lens services are considered "non-medical" and are separate procedures that are typically not covered by insurance.

Contact Lens Yearly Evaluation Fee starts at: $49.00

A contact lens yearly evaluation is an evaluation of the same contact lenses that you currently wear, provided you had your eyes examined approximately one year ago. If your prescription needs to be changed during the year and you have already paid the evaluation fee, you will be charged the difference between the evaluation and the new fit. CRT lenses carry different fees.

New Contact Lens Evaluation Fees

All evaluation of new and existing patients will be charged as stated below. These fees will cover all services and visits needed in the fitting for 6 months. If patient does not return for their fittings within 6 weeks of their exam, additional fees may apply to finalize the prescription.

Soft Spherical:	$65.00
Soft Toric, Extended Wear, Planned Replacements	$85.00
Soft Spherical Monovision:	$85.00
Soft Toric Monovision:	$95.00
RGP Spherical:	$85.00
Soft Bifocal:	$95.00
RGP Torics, Bitorics, Monovision, Bifocals:	$110.00
Soft Sphere/Toric Custom Lenses	$155.00
Pediatric (Children age 6-10 or > +6.00/ -6.00 prescriptions):	$155.00
Pediatric (Children under age 6):	$185.00

If you are a brand new contact lens wearer, a $25.00 fee will be added to any evaluation fees for an insertion, removal training and contact lens care training class.

I acknowledge that I am aware of the additional fees listed here regarding contact lenses and understand the Insurance Authorization, Financial & Privacy Policies.

Patient Name: _____ X_____Date_____

Please be sure you have filled out both sides.

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Patient Medical History

Welcome to our office. Many conditions can affect your vision and eye health. Please complete this form as completely as possible in order for us to provide you with the best care. This information is confidential and is for medical records only. Please be sure to complete both sides of the form.

Patient Name:_____ DOB:_____
Primary Care Provider:_____ Clinic:_____

Reason for Visit

❑ Annual Exam ❑ Vision Therapy/Rehab Evaluation ❑ Contact lens evaluation ❑ Other:_____

Are you experiencing any of these EYE symptoms?

❑Redness	❑ Burning/Itching	❑ Tearing/Watery	❑ Mattering/Goopy	❑Dry eye
❑ Blurred vision	❑ Eye strain	❑ Pain/Soreness	❑Sensitivity to light	❑ Headaches
❑ Double vision	❑ Tired eyes	❑Sandy/gritty feeling	❑Burning/itching	

❑Problems with glare, reflections or driving at night? ❑Losing your place, headaches or struggles when reading?

Other (explain):_____

Would you like information about Laser Vision Correction Surgery? ❑ Yes ❑ No
Would you like to non-surgically be able to see without glasses or contacts during the day? ❑ Yes ❑ No

Current Vision

When was your last eye exam?_____ Where?_____

Glasses: Do you currently wear glasses? ❑Yes ❑No *If yes, answer the questions below. If no, continue to contact lenses section.*
How old are your glasses? _____
How often do you wear your glasses? ❑Full-time ❑As needed for driving or reading ❑Do not wear

Contact Lenses: Do you currently wear contact lenses? ❑Yes ❑No *If yes, answer the questions below. If no, continue to symptoms*
What is the brand and name of your contact lenses? _____
How often do you replace your contact lenses? ❑Daily ❑Weekly ❑2 weeks ❑Monthly ❑ 3 months ❑6 months ❑Annually
What solutions do you use to care for contact lenses? ❑Renu ❑Optifree ❑Clear Care ❑Other:_____
What would your change about your contact lenses? ❑Comfort ❑Fit ❑Clarity of Vision ❑ Convenience
❑ Other:_____

Social/Developmental History

What is your occupation/grade in school?_____
Do you work at a computer? ❑Yes ❑No If yes, how many hours per day are you on the computer? _____
What types or hobbies/activities/sports do you enjoy? ❑Sewing ❑Golf ❑Fishing ❑Swimming ❑Contact Sports
❑Other: _____
Do you smoke? ❑No ❑Yes If yes, how much per day do you smoke? _____
Do you consume alcohol? ❑No ❑Yes If yes, how much do you drink per week?_____
Under 18: Typical letter grades: _____ School:_____

Does your child have any siblings?	❑Yes ❑No	If Yes, please list names and ages:
Does your child struggle with reading?	❑Yes ❑No	
Does your child struggle with mathematics?	❑Yes ❑No	
Has your child had any delays in development? (ie. Crawling, Walking, Talking, etc)	❑Yes ❑No	

Family History Has anyone in your family been diagnosed with any of the following (check all that apply):

❑Blindness ❑Glaucoma ❑Amblyopia ❑Cataracts ❑Macular Degeneration ❑Strabismus (eye turn)
❑Diabetes ❑High blood pressure ❑Cancer: type_____ ❑Family History Unknown

Be sure to complete both sides of this form.

Do you NOW or have your EVER had any of the following conditions or illnesses?

Ocular/eye conditions
Glaucoma ☐Yes ☐No
Cataract ☐Yes ☐No
Macular Degeneration ☐Yes ☐No
Surgery, type:_____ ☐Yes ☐No
Eye patching ☐Yes ☐No
Inflammation of eyes ☐Yes ☐No
Strabismus (eye turn) ☐Yes ☐No
Amblyopia ("lazy" eye) ☐Yes ☐No
Retinal Problems ☐Yes ☐No
Injury to eyes ☐Yes ☐No
Keratoconus ☐Yes ☐No
Other:_____ ☐Yes ☐No

Constitutional Problems
Developmental delays/disabilities ☐Yes ☐No
Cancer, type:_____ ☐Yes ☐No
Fatigue syndrome ☐Yes ☐No
Other:_____ ☐Yes ☐No

Ears, Nose, Throat problems
Hearing Loss ☐Yes ☐No
Sinusitits ☐Yes ☐No
Dry mouth ☐Yes ☐No
Other:_____ ☐Yes ☐No

Neurological problems
MS ☐Yes ☐No
Epilepsy ☐Yes ☐No
Cerebral Palsy ☐Yes ☐No
Tumor ☐Yes ☐No
Stoke/CVA ☐Yes ☐No
Headache ☐Yes ☐No
Autism Spectrum Disorder ☐Yes ☐No
Other:_____ ☐Yes ☐No

Psychiatric problems
Depression ☐Yes ☐No
AD(H)D ☐Yes ☐No
Anxiety Disorder ☐Yes ☐No
Bipolar Disorder ☐Yes ☐No
Other:_____ ☐Yes ☐No

Cardiovascular problems
Hypertension ☐Yes ☐No
Stroke/CVA ☐Yes ☐No
Heart disease ☐Yes ☐No
Vascular disease ☐Yes ☐No
Congestive Heart Failure ☐Yes ☐No
Other:_____ ☐Yes ☐No

Respiratory problems
Cigarette smoker ☐Yes ☐No
Asthma ☐Yes ☐No
Bronchitis ☐Yes ☐No
Emphysema ☐Yes ☐No
Chronic obstruction ☐Yes ☐No
Sleep apnea ☐Yes ☐No
Other:_____ ☐Yes ☐No

Gastrointestinal problems
Crohn's ☐Yes ☐No
Colitis ☐Yes ☐No
Ulcer ☐Yes ☐No
Acid Reflux ☐Yes ☐No
Celiac Disease ☐Yes ☐No
Other:_____ ☐Yes ☐No

Genitourinary problems
Kidney disease ☐Yes ☐No
Prostate disease/cancer ☐Yes ☐No
STD-herpetic/chlamydia ☐Yes ☐No
Benign Prostate Hypertrophy ☐Yes ☐No
Pregnant or Nursing ☐Yes ☐No
Other:_____ ☐Yes ☐No

Musculoskeletal problems
Arthritis ☐Yes ☐No
Osteoarthritis ☐Yes ☐No
Fibromyalgia ☐Yes ☐No
Muscular dystrophy ☐Yes ☐No
Ankylosing Spondylitis ☐Yes ☐No
Osteoporosis ☐Yes ☐No
Gout ☐Yes ☐No
Other:_____ ☐Yes ☐No

Skin problems
Eczema ☐Yes ☐No
Rosacea ☐Yes ☐No
Psoriasis ☐Yes ☐No
Herpes Simplex/Cold Sores ☐Yes ☐No
Herpes Zoster/Shingles ☐Yes ☐No
Other:_____ ☐Yes ☐No

Endocrine problems
Type 2 diabetes ☐Yes ☐No
Type 1 diabetes ☐Yes ☐No
Thyroid dysfunction ☐Yes ☐No
Hormonal dysfunction ☐Yes ☐No
Other:_____ ☐Yes ☐No

Blood/lymph problems
Anemia ☐Yes ☐No
Large-volume blood loss ☐Yes ☐No
Ulcer ☐Yes ☐No
High cholesterol ☐Yes ☐No
Other:_____ ☐Yes ☐No

Allergy/immunologic problems
Drug allergies ☐Yes ☐No
Environmental allergies ☐Yes ☐No
Rheumatoid arthritis ☐Yes ☐No
Lupus ☐Yes ☐No
Sjogren's syndrome ☐Yes ☐No
Other:_____ ☐Yes ☐No

Other:_____

Have you had a concussion, brain injury or car accident? ☐Yes ☐No Dates:_____

List any medicine allergies:_____

List any medications you are currently taking and how often:

_____

_____

Other concerns/questions that you would like addressed today?_____

Signature_____ **Date**_____

COLLEGE OF OPTOMETRISTS IN VISION DEVELOPMENT

PREVENTION • ENHANCEMENT • REHABILITATION

Patient's Name: _____

Completed By: _____

Date: _____

Check the column which best represents the occurrence of each symptom.	Never 0	Seldomly 1	Occasionally 2	Frequently 3	Always 4
Blur when looking at near					
Double Vision					
Headaches with near work					
Words run together reading					
Burning, itchy, watery eyes					
Falls asleep reading					
Sees worse at the end of the day					
Skips/repeats lines when reading					
Dizziness/nausea with near work					
Head tilt/closing one eye when reading					
Difficulty copying from chalkboard					
Avoids near work/reading					
Omits small words when reading					
Writes uphill/downhill					
Misaligns digits/columns of numbers					
Reading comprehension down					
Poor/inconsistent in sports					
Holds reading too close					
Trouble keeping attention on reading					
Difficulty completing assignments on time					
Always says "I can't" before trying					
Avoids sports/games					
Poor hand/eye (poor handwriting)					
Does not judge distance accurately					
Clumsy, knocks things over					
Does not use his/her time well					
Does not make change well					
Loses belongings/things					
Car/motion sickness					
Forgetful/poor memory					

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