

Eyecare Specialties

Dr. Michael Semmler
Dr. Susan Semmler
Optometrists

How did you first hear about our office?

- Yellow Pages newspaper Village Greeters
 Radio Community Event
 Friend/Relative... Who? _____
 Physician... Who? _____

Our Mission

To enhance each patient's quality of life by caring for their eye health and visual well being. We will utilize modern training and technology to provide quality eye care and products of value while treating each patient like family.

WELCOME TO OUR OFFICE

(PLEASE PRINT)

Name _____
Today's Date _____
Spouse or Parent _____
Mailing Address _____
City, State, Zip _____
Date of Birth _____ Age _____ Sex: M F
Home Phone _____ Work Phone _____
Social Security # _____
Employer (or School) _____
Occupation (or Grade) _____
Vision/Health Insurance: Medicare Medicaid
 VSP BlueCross Other _____

Do you experience..... (check those that apply)

- | | |
|--|---|
| <input type="checkbox"/> Burning | <input type="checkbox"/> Uncomfortable glasses |
| <input type="checkbox"/> Itchiness | <input type="checkbox"/> Sudden loss of vision |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Sensitivity to light |
| <input type="checkbox"/> Watery Eyes | <input type="checkbox"/> Fainting or dizziness |
| <input type="checkbox"/> Double Vision | <input type="checkbox"/> Blurry distance vision |
| <input type="checkbox"/> Flashes of Light | <input type="checkbox"/> Blurry near vision |
| <input type="checkbox"/> Glare or Reflection | <input type="checkbox"/> Gritty feeling in eyes |
| <input type="checkbox"/> Soreness | <input type="checkbox"/> Objects floating in vision |
| <input type="checkbox"/> Eye Strain | <input type="checkbox"/> Trouble seeing at night |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Dryness |
| <input type="checkbox"/> Redness | <input type="checkbox"/> Other _____ |

I authorize the release of payment for medical benefits to Eyecare Specialties and any medical information to any doctor and to my insurance carrier as is necessary to process all claims. I understand that I am ultimately responsible for the balance of my account.

Patient's Signature _____ Date: _____

MEDICAL HISTORY

- | | | |
|--|--|--------------------------------------|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Eye Injury |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Cancer | <input type="checkbox"/> Eye Surgery |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Cataracts |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Skin Disorder | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Other _____ | | |

CURRENT MEDICATIONS (Rx or over the counter)

Medication Name

- Antihistamines _____
 Blood Pressure Pills _____
 Diuretic (water pill) _____
 Sleeping Tablets _____
 Eye Drops _____
 Others _____
 Allergies to Medication _____
Date of Last Eye Exam _____
Name of Last Eye Doctor _____
Date of Last Physical Exam _____
Name of Physician _____

FAMILY EYE HISTORY

Relationship to you

- Blindness _____
 Glaucoma _____
 Other eye disease _____

VISUAL NEEDS

Do You..... (check the box if your answer is yes)

- Work at a computer for long periods of time?
 Have one pair of glasses?
 Want information on thinner, lighter lenses?
 Wear bifocals?
 Want information on lineless bifocals?
 Prefer not to wear your glasses at times?
 Spend a lot of time outdoors?
 Ever find a need for prescription sunglasses?
 Have problems with glare or reflections (ex: night driving)?
 Do work requiring safety glasses?
 Participate in sport activities? What? _____
 Want more information about corrective vision surgery?
 Wear or ever tried wearing contact lenses?
What kind? _____

SOCIAL HISTORY

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer. This information is important for medical purposes as well as compliance with insurance directives.

YES NO Do you use tobacco products?

YES NO Do you drink alcohol?

If so, how much? _____

I would prefer to discuss my Social History information directly with my doctor.

How will you settle your account today?

- Check Credit Card cash