WELCOME TO VILLA OPTOMETRY INC.

PATIENT INFORMATION

Name: Last__________________________________, First__________________________ Circle: Male / Female Date:____/____/____

Address:____ City: _______________________ State: ______ Zip: __________

Home Phone: ________________________ Cell Phone: _________________________ Work Phone: ____________________________

Email Address: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Date of Birth: ___/____/______ Social Security Number: _______________ Primary Care Physician: ___________________________

Occupation: ____ Employer: ____

How did you hear about our office? ____

INSURANCE INFORMATION

Name of Vision Insurance: __________________________ Patient relationship to primary member: _____________________________

Primary member's: Full Name: ___________________________ Date of Birth: ___/____/____ Social Security #: __________________

Name of Medical Insurance: ____ Policy #: ______________________

Primary member's: Full Name: ___________________________ Date of Birth: ___/____/____ Social Security #: __________________

AUTHORIZATIONS

PAYMENT: Fees are due in full when services are rendered. Deposit is required to order materials. Phone verification of insurance coverage does not guarantee benefits or payment. Your signature on this form will serve as your signature on file for processing insurance forms. I have read and understand the above and I agree to pay for services and materials which I order that my insurance does not cover. Please check your preferred method of payment.

☐ Cash / Check ☐ Credit / Debit Card ☐ Care Credit (Information available upon request)

AUTHORIZATION TO RELEASE MEDICAL INFORMATION: I authorize Villa Optometry, Inc. to release/ request medical information on my behalf to/ from any entity to assist in my medical care per my request. This assignment will remain in effect until revoked in writing.

PRIVACY: My signature below acknowledges that I was provided the opportunity to receive/ review a copy of Villa Optometry Inc.'s Privacy Policy Notice.

Signature of responsible party: ____ Date: _____/_____/_____

Printed Name: ____

PLEASE COMPLETE THE REVERSE SIDE

REASON FOR VISIT

What is the primary reason for your visit today? ____

What services are you interested in receiving today? (Check all that apply)

- ☐ General Eye Exam
- ☐ Glasses Exam
- ☐ Contact Lens Fitting
- ☐ Evaluation for Laser Vision Correction
- ☐ Treatment for Eye Infection, Injury, or other specific problem (specify) ____________________ ____

Are you experiencing any of the following ocular or vision related symptoms?

- ☐ Blur at Distance
- ☐ Blur at Near
- ☐ Trouble with Computers
- ☐ Eye Pain
- ☐ Eye Redness
- ☐ Eye Itching
- ☐ Dry Eyes
- ☐ Tearing
- ☐ Headaches
- ☐ Double Vision
- ☐ Floaters
- ☐ Flashes
- ☐ Light Sensitivity
- ☐ Other (specify) ________________ ________________________
- ☐ **NONE OF THE ABOVE**

If so, please provide details (location, severity, duration, timing, context, etc.) ____ ____

PATIENT OCULAR HISTORY

Date of last eye exam: _____/______/______ Previous Eye Doctor Name: ____

Were your eyes dilated? ☐ Yes ☐ No Do you wear: ☐ Glasses ☐ Contact Lenses

Please list any eye drops, eye ointments, or eye vitamins you use:
____

Have you had any of the following:

- ☐ Eye Injury/Trauma
- ☐ Refractive Surgery/LASIK (year)_________
- ☐ Cataract Surgery (year)_________
- ☐ Other Eye Surgery (specify)________________________
- ☐ Injections to the Eye
- ☐ Laser Treatments to the Eye
- ☐ Retinal Hole/Tear/Detachment
- ☐ Other (specify)_________________________________
- ☐ **NONE OF THE ABOVE**

Do you currently have:

- ☐ Glaucoma
- ☐ Cataracts
- ☐ Macular Degeneration
- ☐ Diabetic Retinopathy
- ☐ Keratoconus
- ☐ Other (specify)__________________________________
- ☐ **NONE OF THE ABOVE**

MEDICAL HISTORY

Date of last physical exam: ____/_____/_____ Name of Physician: ____

Please list current medications: ____
____

Do you have or have you been treated for:

- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Heart Disease
- ☐ Stroke
- ☐ Diabetes (year diagnosed)___________
- ☐ Thyroid Problems
- ☐ Cancer
- ☐ Arthritis
- ☐ Sinus Problems
- ☐ Allergies to medications (specify)____________________
- ☐ Other (specify)_________________________________
- ☐ **NONE OF THE ABOVE**

Do any of your **immediate family members** have:

- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Cancer
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Keratoconus
- ☐ Blindness
- ☐ Color Deficiency
- ☐ Other (specify)_______________________________
- ☐ **NONE OF THE ABOVE**