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ADULT'S QUESTIONNAIRE

Name: ____ Date: ________________
Address: ____
Town: ______________________________ State: ___________ Zip Code: ___________
Home telephone: ___________________ Date of Birth: ___________________________
Cell phone: __________________ Email address: _________________________________
Occupation: _________________________ Place of Work: __________________________
Work Telephone: ____________________ Referred by: ___________________________
What is your main problem or concern? ____
____
____

May we add you on Facebook?___ If yes, what is your contact name?________________

Are you presently experiencing any of the following?

__ Blurred vision
__ Burning of the eyes
__ Tearing/watery eyes
__ Redness of the eyes
__ Short attention span
__ Back or neck pain
__ Eye(s) turn in/out/up/down
__ Headaches
__ Itchy eyes
__ Light sensitivity
__ Double Vision
__ Slow reading
__ Difficulty in depth perception
__ Difficulty with driving
__ Poor sports performance
__ Tired/sleepy doing visual tasks
__ Loss of place while reading
__ Low reading comprehension
__ Computer visual discomfort
__ Clumsiness/bumping into things

Other: ____
____
Are there any special visual demands you have at work or at home? _________________
____
Are there any hobbies or recreational activities with special visual demands? _________
____

VISION HISTORY

Date of your last vision or eye exam: ___________________
Eye Doctor's name: ____
Eye Doctor's address: ____
Diagnoses and recommendations: ____
____

Were glasses prescribed? ______ If so, do you wear them now? _________
What do you wear the glasses for? Distance ____ Near _____
Have you ever been involved in vision therapy? _____ When? ____________________
Doctor's name and address: ____
Have you ever had an eye patched? _______ If so, when? ________________________
Detail any history of eye disease or surgery: ____________________________________

____
Do you ever see bright flashes of light ____ or floating spots? _____
Have you ever had an injury to your eye or eyes? ____ If so, please explain: __________

____
Have you ever suffered a head or brain injury? ____ If so, please explain: ____________

____

CONTACT LENS HISTORY

Do you wear contact lenses? ____ Soft or RGP? _____ If not, are you interested? _____
When did you start wearing contact lenses? ____________
Type and brand of contact lenses: ____
How many hours per day: _____________ How many days per week: _____________

MEDICAL HISTORY

__ High blood pressure __ Diabetes __ Arthritis
__ Cancer __ Allergies/Asthma __ Heart disease
__ Glaucoma __ Cataracts
__ Other ____

Please list any medications you are currently using: ______________________________

____

Name of your physician: ____
Address: ____
May we send a report of our findings to your physician? Yes _____ No _____

Is there any family history of: **If so, what relation:**
___ High blood pressure _______________
___ Diabetes _______________
___ Glaucoma _______________
___ Macular degeneration _______________
___ Retinal detachment _______________
___ other eye disease _______________

Signed: _____________________________________ Date: _________________

Your signature acknowledges receipt of our Notice of Privacy Practice and also authorizes us to file insurance claims on your behalf.

FINANCIAL RESPONSIBILITY STATEMENT

To Our Patients with Insurance Benefits:

We will be happy to help you file your insurance claim forms or take assignment on your insurance benefit as designated by the _________________ Plan of which you state you are a member. This service will be provided without additional charge to you. We will also do all that we can to help you receive maximum benefits.

However, in the event that the insurance plan determines that you are not eligible at the time of service, or makes a determination that you are eligible for a reduced level of coverage, by signing this statement you do hereby agree to be financially responsible for any and all charges incurred by you, and not paid by your insurance plan.

RESPONSIBLE PARTY: ____

____
Signature Date

BILLING ADDRESS: ____
Street Address/Apt. #

____
City, State, Zip

____
Telephone

CANCELATION POLICY

All patients will be charged $55.00 for missed appointments if 48 hours notice is not given for cancellation.
I have read this statement and agree to the above.

Patient's or parent's signature ____ Date
____

CELL PHONE POLICY

PLEASE PUT YOUR CELL PHONE ON SILENT MODE
During evaluations and vision therapy sessions, it is important that you are not distracted or your child during the appointment. During a child's evaluation, it is also important that you observe the testing and how your child responds.
If for some reason there is a call you have to take, please step out of the room to do that.

Please initial __________ Date _________________