

# WELCOME TO OUR OFFICE!

Please fill in the blanks and answer the questions below. How did you learn about our office? \_\_\_\_\_

Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Pager: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Birth Date: \_\_\_\_\_ SS#: \_\_\_\_\_ Email: \_\_\_\_\_  
Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Ins. Co: \_\_\_\_\_ Policy No: \_\_\_\_\_ Group No: \_\_\_\_\_

Reason for your visit today? \_\_\_\_\_

Are you interested in: Contacts?  Y  N Laser Vision Correction?  Y  N Clear vision without daytime glasses, contacts or surgery?  Y  N

## Dilation is the best way to examine the inside of your eyes.

Many times it is necessary to dilate your eyes to better assess certain eye and health conditions. We will recommend dilating your eyes if you or anyone in your family has cataracts, glaucoma, diabetes or hypertension (high blood pressure), or if you are experiencing flashing lights, floaters, or have a high degree of nearsightedness. The doctor may also recommend dilation for certain other medical conditions. The effect of dilation usually lasts from 2-6 hours and involves light sensitivity. We suggest you have someone drive you home as your distance vision may be blurry.

By signing below, I acknowledge that I have been advised that dilation is an essential part of a vision and eye health examination. I understand that if not dilated, my doctor might miss seeing inside my eyes for signs of serious health problems such as but not limited to diabetes, high blood pressure, glaucoma, cataracts, and possibly even cancer. I hold Dr. Ditto and his agents harmless for any circumstances which might later occur as a result of a condition not detected.

**SIGN ONLY IF DECLINING DILATION >>>>>** Signature: \_\_\_\_\_ Date: \_\_\_\_\_

When was your last eye exam? \_\_\_\_\_

Who was the Dr.? \_\_\_\_\_

Please answer the following:

Blurred far away vision?  Y  N  
Blurred close up vision?  Y  N  
Headaches?  Y  N  
Fatigue or eyestrain when using a computer?  Y  N  
Do you lose your place when you read?  Y  N  
Have you ever had eye surgery?  Y  N  
Do your eyes get dry a lot?  Y  N  
Do your eyes get watery a lot?  Y  N  
Do your eyes itch?  Y  N  
Have you ever seen flasher of lights?  Y  N  
Do you see double (two of things)?  Y  N  
Have you had an eye or head injury?  Y  N

What medications do you take?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What are you allergic to?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

When was your last physical exam? \_\_\_\_\_

Who was the Dr.? \_\_\_\_\_

Do you or anyone in your family have:

High blood pressure?  No  Self  Family  
Heart Disease?  No  Self  Family  
High Cholesterol?  No  Self  Family  
Diabetes?  No  Self  Family  
Thyroid Disease?  No  Self  Family  
Cancer?  No  Self  Family  
Glaucoma?  No  Self  Family  
Retina Problems?  No  Self  Family

Do you smoke?  Y  N

Do you use recreational drugs?  Y  N

Alcohol consumption per day? \_\_\_\_\_

Females, are you pregnant?  Y  N

Other? \_\_\_\_\_

I am the patient, the parent, or the guardian of the minor child whose name appears above. I hereby consent to have Dr. Ditto and Village Vision to perform such eye care and treatment as it deems necessary or appropriate for myself, or my child. I further agree to pay for goods and services purchased from Dr. Ditto and Village Vision. I understand I am financially responsible for all charges incurred during the course of this visit whether covered by my insurance or not. I understand that there may be tests performed which my insurance company does not regard as a part of what they consider to be a standard vision examination. I authorize payment to the physician directly and also authorize the physician and/or staff to release any information needed in the processing of any claims. I understand there is a \$20 return check fee and that finance charges of 1.5% per month will accrue for balances 30 days or More past due.

\_\_\_\_\_  
Patient or Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Guardian if Patient is a Minor