PRE-VISIT PACKET

Demographic Information

First Name: | Middle Name:
Last Name: | Gender:
Date of Birth: | Preferred Language:
Address 1:
Address 2: | City/State:
Zip Code:

Contact Information

Cell Phone:
Other Contact Methods
Home Phone: | Email Address:
Work Phone:
Emergency Contact Name: | Emergency Contact Phone:
Relation to Patient:

Primary Insurance Information

Insurance Company: | Plan Name:
Group Number: | Insurance Policy Number / Member ID:
Insurance Provider Phone Number: | Policyholder Full Name:
Date of Birth of Policyholder: | Relation to Policyholder:
Policy Number / Member ID of Policyholder:

Medical History

1. When was your last eye exam and who was your previous eye doctor?

2. Reason for today's visit:

3. Which of the following topics are you interested in discussing with your eye doctor at your visit? (Check all that apply)
   - ☐ Glasses
   - ☐ Contacts
   - ☐ Laser Vision Correction
   - ☐ Neurolens
   - ☐ Ortho-K

4. Do you wear glasses?
   - ☐ Yes
   - ☐ No

If yes, how long have you worn glasses?

5. Do you wear contact lenses?
   - ☐ Yes
   - ☐ No

If yes, are your contact lenses comfortable?

6. On average, how many hours do you wear your contact lenses per day?

7. What best describes your symptoms? (Check all that may apply)
   - ☐ Blurred Distance Vision
   - ☐ Blurred Computer Vision
   - ☐ Blurred Near Vision
   - ☐ Change in Pupil Size
   - ☐ Double Vision
   - ☐ Drooping Eyelids
   - ☐ Flashes/Floaters in Vision
   - ☐ Sandy or Gritty Feeling (Foreign Body Sensation)
   - ☐ Headaches
   - ☐ Irritation
   - ☐ Itchy Eyes
   - ☐ Migraines
   - ☐ Eye Pain or Soreness
   - ☐ Glare/Light Sensitivity
   - ☐ Redness/Dry Eye
   - ☐ Burning/Swelling
   - ☐ Tearing/Watering
   - ☐ Loss of Vision
   - ☐ Night Vision Problems
   - ☐ Stiffness/ Pain in Neck or Shoulders
   - ☐ Dizziness
   - ☐ Numbness/ Tingling
   - ☐ None of the Above
   - ☐ Other Conditions Not Listed: ____

8. Do you have or have you had, any of the following medical conditions? (check all that apply)
   - ☐ Age Related Macular Degeneration
   - ☐ Diabetes
   - ☐ High Blood Pressure
   - ☐ Glaucoma
   - ☐ Cataracts
   - ☐ Eye Injury
   - ☐ Eye Infections
   - ☐ Crossed Eyes
   - ☐ Lazy Eye
   - ☐ Retinal Disease
   - ☐ Vascular Disease
   - ☐ Heart/Chest Pain
   - ☐ LASIK (Laser Vision Correction)
   - ☐ Multiple Sclerosis
   - ☐ Stroke
   - ☐ Seizures
   - ☐ None of the Above
   - ☐ Other Conditions Not Listed: ____

9. List all major injuries, surgeries, and/or hospitalizations you have had:

10. List any medications you take (including pills, creams, drops, oral contraceptives, aspirin, over-the-counter medications, and home remedies):

11. Do you have any medication allergies?
- ☐ Yes
- ☐ No

If yes, please list them:

The demands of the digital age mean our eyes are working harder than ever. Most people don't realize eye misalignment could be the driver of painful symptoms that show up in the body. We are pleased to offer Neurolens, an FDA approved technology to measure eye misalignment and help your doctor prescribe eyeglasses that correct your vision and alleviate your symptoms.

The questions below are some of the identifiers to help us see if you could benefit from the technology we have in our practice.

12. Do you utilize specialty services and/or treatments to address symptoms related to: (check all that apply)
- ☐ Headache
- ☐ Motion Sickness
- ☐ Neck Tension
- ☐ None of the Above
- ☐ Other, please specify:____

13. How many hours do you spend per day on a screen (Computer, Tablet, Phone, etc.)?

14. Are you interested in learning more about Neurolens?
- ☐ Yes
- ☐ No

Our practice is pleased to offer our patients eyewear to help with hearing. Nuance Audio is an innovative FDA approved solution that integrates high-quality hearing technology into fashionable frames, designed to help individuals with mild to moderate hearing loss by providing an invisible and comfortable hearing aid.

15. Do you have trouble understanding speech and noise?
- ☐ Yes
- ☐ No

16. When you're in a crowded situation, do you feel like people are mumbling?
- ☐ Yes
- ☐ No

17. Would it be better for you if people spoke more clearly?
- ☐ Yes
- ☐ No

18. Are you interested in learning more about Nuance Audio?
- ☐ Yes
- ☐ No

SOCIAL/ FAMILY HISTORY

19. Are you pregnant and/or nursing?
- ☐ Yes
- ☐ No
- ☐ N/A

21. Do you have any family history (parents, grandparents, siblings, children; living or deceased) of the following conditions? Please check any that apply.

- ☐ Blindness
- ☐ Cataract
- ☐ Crossed Eyes
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Retinal Detachment/Disease
- ☐ Arthritis
- ☐ Cancer
- ☐ Diabetes
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Lupus
- ☐ Thyroid Disease
- ☐ None of the Above
- ☐ Other: ____

Eyeglass and Contact Lens Acknowledgement & Digital Prescription Consent Form

I would like to receive my eyeglasses and/or contact lens prescription when finalized via:

- ☐ Text
- ☐ Email
- ☐ Printed copy

Email/ Cell Phone #:

Patient Signature:

Acknowledgement of Notice of Privacy Practices

Patient Name (Print): ____ Date: ____________________

Acknowledgement of Notice of Privacy Practices (*all patients read and sign*):

I acknowledge that I have received or been offered the HIPAA Notice of Privacy Practices which describes the uses and disclosures of my protected health information by the Practice and informs me of my rights with respect to my protected health information. I give consent for the doctor to view my imported medication history.

Patient Signature (*or Guardian, if under 18 years old*):

____ Date: ____________________

I give my permission for my personal health information to be discussed with the following individuals:

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