**BOERNE VISION CENTER PATIENT FORM - INFORMATION**

| Patient's Last Name | First | Prefered Name |
|---|---|---|
| Address (Street , City, State, Zip) | | |
| Phone, cell | Phone, other | |
| Email | | |
| Patient Social Security Number | Date of Birth | Sex: *(Male \| Female)* |
| Race: (*Asian \| Black \| Native American \| Pacific Islander \| White \| Other \| Mixed-race)* | | Ethnicity: (*Hispanic \| not Hispanic)* |
| Emergency Contact Name | Phone | Relationship |

**I Authorize Boerne Vision Center to disclose/release my medical/protected health information to:**
**☐ My emergency contact ☐ The individual(s) listed____________________________________________**

## REASON FOR TODAY'S VISIT ☐Eye Exam/Glasses ☐Contacts ☐Diabetic Eye Exam ☐Other_________________

**Past Eye Surgeries** ☐None ☐Cataracts ☐LASIK ☐Lasers ☐Other:____________________________________________
**Date of last eye exam?** _________________________
**Currently wearing Contact Lenses?** ☐None ☐Dailies ☐2 week ☐Monthly ☐Gas Permeable ☐Other _________________
**Contact lens Brand** ___________________________________ **Contact lens Solution** _____________________________
**Primary Care Doctor**_________________________________ **Other Doctors**_____________________________________
**Currently wear glasses?** ☐No ☐Sunglasses ☐Single vision ☐Progressives ☐Readers ☐Bifocals ☐Trifocals
**How old are the glasses?** _________________________

## REVIEW OF SYSTEMS

**Eye** - Are you currently experiencing, or have experienced any of the following? If you do **not** select No.

☐Blurry Vision ☐Burning ☐Discharge ☐Double Vision ☐Dryness ☐Tearing/Watering
☐Eye Infection ☐Eye Pain ☐Floaters or Spots ☐Light Sensitivity ☐Headaches ☐Itching
☐Light Flashes ☐Halos ☐Redness ☐Sandy or Gritty Feeling ☐Other_______________________

☐No **General** ☐Pregnant ☐Fatigue ☐Fever ☐Night Sweat ☐Weight Gain ☐Weightloss
☐No **Blood Pressure Control** ☐Good control ☐Borderline ☐Poor Control ☐Unknown Control
☐No **Diabetes Control** ☐Good control ☐Borderline Control ☐Poor Control ☐Unknown Control
☐No **Genitourinary** ☐Genital Discharge ☐Genital Lesions ☐Painful Urination ☐Urgency
☐No **Gastrointestinal** ☐Diarrhea ☐Nausea or Vomiting ☐Abdominal Pain ☐Constipation
☐No **Psychiatric** ☐Anxiety ☐Depression ☐Insomnia
☐No **Endocrine/Metabolic** ☐Cold Intolerance ☐Excess Hunger ☐Excessive Thirst ☐Frequent Urination ☐Heat Intolerance
☐No **Ear, Nose, Throat** ☐Dizziness ☐Hearing Loss ☐Hoarseness ☐Ringing in Ears ☐Sore Throat
☐No **Allergies** ☐Itching ☐Hives ☐Chronic Runny Nose ☐Seasonal Allergies
☐No **Skin/Integumentary** ☐Hair Loss☐Rash ☐Skin Lesions
☐No **Cardiovascular** ☐Chest Pain ☐Irregular Heartbeat ☐Shortness of Breath
☐No **Musculoskeletal** ☐Back Pain ☐Joint Pain ☐Muscle Aches ☐Stiffness
☐No **Respiratory** ☐Cough ☐Trouble Breathing ☐Wheezing
☐No **Hematologic** ☐Bleeding ☐Bruising ☐Tender Nodes
☐No **Neurological** ☐Balance Problem ☐Headache ☐Numbness ☐Tingling

**Next Page---->**

**Has a family member experienced, or been treated for any of the following?**
☐No ☐Unknown ☐Cataracts ☐Glaucoma ☐Macular Degeneration ☐Hypertension ☐Diabetes ☐Cancer ☐Heart Disease
☐Retinal Detachment ☐Crossed Eye☐Lazy Eye

**BOERNE VISION CENTER PATIENT FORM - INFORMATION**

**Alcohol Use** ☐None ☐Socially ☐Daily☐Former **Tobacco Use** ☐None ☐Former ☐Smoker

## Current Medications

☐ No Meds ☐ Gave list to front desk

**☐ Will write medications below. Please also include eye drops / over-the-counter / prescription drug name and dosage below. Also, Please list the diseases that your medications are taken for. (**example- Metformin 500mg for Diabetes**)**

**Medication Drug Allergies** ☐No known Drug Allergy

☐ Yes:______________________ Reaction____________________________

☐ Yes:______________________ Reaction____________________________

**Pharmacy**

Address____________________________

Phone Number_______________________

I have read below and I understand the **DILATION DISCLAIMER, CONTACT LENS PATIENT AGREEMENT, FINANCIAL POLICY, REFRACTION POLICY, WARRANTY POLICY, NO SHOW POLICY, AND NOTICE OF PRIVACY PRACTICES** of Boerne Vision Center PA. I further understand that if I have any questions regarding any of these policies, I am able to speak to an associate who can answer my questions while I am in the office or by sending an email to office@boernevisioncenter.com.

Sign____________________________________________________ Date ___________________________

Signature of Patient, Parent/Guardian (Check one): **☐SELF ☐PARENT ☐GUARDIAN**

**I consent to dilate my eyes (check one) ☐YES ☐DECLINE ☐RESCHEDULE**

**I want a contact lens exam $50-$75 (check one) ☐YES ☐DECLINE ☐RESCHEDULE**

**I would like a Wellness Scan for $39 (check one)☐YES ☐DECLINE ☐RESCHEDULE**

**INSURANCE INFORMATION - Please fill out if you didn't provide us with card(s) or information previously.**

| **Vision Insurance** | *NA \| Eyemed \| VSP \| Davis \| Boon Chapman \|Other:* | |
|---|---|---|
| Vision Insurance Member Name | Vision Insurance Member Date of Birth | |
| Vision Insurance Member ID# | Vision Insurance Employer | |
| **Primary Medical Insurance** | *NA \| Aetna \| BCBS \| Humana \| Medicare \| Other:* | |
| Primary Member Name | Primary DOB | Primary Employer |
| Insurance ID# | Insurance Policy #/ Group ID # | |
| Primary Member Social Security # | Your Relationship to Primary Member:<br>*Self \| Spouse \| Dependent \| Other:* | |
| **Secondary Medical Insurance** | *NA \| AARP \| Aetna \| BCBS \| Humana \| Medicare \| Other:* | |
| Secondary Member Name | Secondary Member Date of Birth | |
| Secondary Medical Insurance ID# | Secondary Medical Insurance Policy #/Group ID# | |
| Secondary Member Social Security# | Relationship to Secondary Insurance: .<br>*Self \| Spouse \| Dependent \| Other:* | |

## BOERNE VISION CENTER WELLNESS SCREENING

We pride ourselves on providing our patients with the best possible standard of care. Because of this, we recommend the Wellness Screening retinal scan on all of our patients during their annual eye exam. The Wellness Screening takes an image of the back of your eye where potential vision threatening disease can be found. Those diseases include **diabetes, glaucoma, certain cancers, retinal tears and cardiovascular issues**. Along with ruling out potential diseases, the Wellness Screening will allow our Doctors to have a baseline image to compare your eye health year after year.

As part of your pre-work up we can capture retinal images during your visit today. All images will be reviewed by your Doctor. If you have any questions about your images our Doctors are always happy to discuss them with you. Please note, when the Wellness Screening is performed you **will not need dilation unless the Doctor states otherwise**. questions about the process or fees feel free to ask our receptionist.

Please select a checkbox on the previous page if you would like to accept or decline this procedure today.

☐ I have read and understood this document
☐ I have questions

Sign:_________________________________ Date:____________