CLARENDON
VISION
DEVELOPMENT
CENTER

Dr. Monika Spokas
Developmental Optometrist

Dr. Linda Weil
Developmental Optometrist

The information in this history form is critical to the evaluation of your vision. This is your opportunity to tell us about all areas in which your vision is not serving you well.

First Name:____________ **Last Name:**____________ **Date:**________

What is your main reason for your visit today? ____________

Are there times when your vision isn't quite right? ____________

HEALTH HISTORY: Circle any conditions that apply to you or that run in your family.

Condition			Condition		
Allergies	☐ Self	☐ Family	Lazy eye	☐ Self	☐ Family
Respiratory disease	☐ Self	☐ Family	Turned eye	☐ Self	☐ Family
Cancer	☐ Self	☐ Family	Color "blind"	☐ Self	☐ Family
Diabetes	☐ Self	☐ Family	Light sensitive	☐ Self	☐ Family
Heart problem	☐ Self	☐ Family	Eyestrain	☐ Self	☐ Family
High blood pressure	☐ Self	☐ Family	Dry eyes	☐ Self	☐ Family
Thyroid	☐ Self	☐ Family	Floaters/spots	☐ Self	☐ Family
Migraines/headaches	☐ Self	☐ Family	Flashing lights	☐ Self	☐ Family
Blindness	☐ Self	☐ Family	Retinal detachment	☐ Self	☐ Family
Head trauma	☐ Self	☐ Family	Macular degeneration	☐ Self	☐ Family
Eye surgery/injury	☐ Self	☐ Family	Cataracts	☐ Self	☐ Family
			Glaucoma	☐ Self	☐ Family

Other medical problems____________

Are you currently under a physicians care? ☐Yes ☐No **Physician's Name**____________

What medications do you currently take? **And for what condition?**

When was your last eye examination? ____________

Do you wear glasses now? .... ☐Yes ☐No

If yes: ☐ for distance only ☐ for near only ☐ full time ☐ when needed ☐ for computer ☐ for sports

How old is your current prescription? ____________

Do you currently wear sunglasses? ☐Yes ☐No **Are they prescription?** ☐Yes ☐No

Do you wear contact lenses at this time? .... ☐Yes ☐No

If yes: How often? ____________ **What brand?**____________

Are you interested in trying contacts? .... ☐Yes ☐No

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Do you experience any of the following discomforts at work or at home?

- ☐ Headaches?
- ☐ Eyestrain?
- ☐ Dry eyes?
- ☐ Occasionally see double?
- ☐ Near print goes in and out of focus?
- ☐ Itchy/red eyes?

OCCUPATION: ____________________

Do you use a computer at work? .... ☐Yes ☐No Ave. hours/day ________

Do you use a computer at home? .... ☐Yes ☐No Ave. hours/day ________

RECREATION AND LEISURE: In what recreational activities do you participate?

- ☐ Reading
- ☐ Video games
- ☐ Musical instrument
- ☐ Arts & crafts
- ☐ Sports: ____________________

Other recreational activities ____________________

Patient's Date of Birth: ____________ ☐ **Male** ☐ **Female**

Cell Phone Number: ____________ **Home Phone Number:** ____________

Email Address: ____________________

Address: ____________ **City:** ____________ **State:** ______ **Zip:** ______

Vision Insurance: ____________ **Medical Insurance:** ____________

Primary Insurance Holder: ____________________

Insurance Holder's Date of Birth: ____________ **Last four digits of SSN:** ________

Payment Policy/HIPAA

Examination and procedure fees are due at the time of service and may be submitted to your major medical insurance carrier. Any applicable co-payments are due at the time of service. If you have insurance coverage for these services or materials, we will submit claims on your behalf. After 30 days, we will expect payment in full if your insurance company has not paid. Any balance 90 days after the date of service will incur a monthly billing service charge of $2.00 or 1.3% (15.6% APR) whichever is greater until the balance is paid in full. Returned NSF checks will be charged a service fee of $35.00.

- I HEREBY AUTHORIZE MY INSURANCE CARRIER TO MAKE PAYMENT DIRECTLY TO CLARENDON VISION DEVELOPMENT CENTER FOR ANY AND ALL SERVICES RENDERED TO ME BY CLARENDON VISION DEVELOPMENT CENTER. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT COVERED BY INSURANCE.
- I HAVE READ AND AGREE TO THE PAYMENT POLICY STATED ABOVE.
- I HAVE RECEIVED HIPAA POLICY STATEMENT AND I HAVE BEEN PROVIDED AN OPPORTUNITY TO REVIEW IT.

Signature ____________________ **Date** ____________

Retinal Imaging

We are pleased to provide our patients with an advanced digital retinal exam. It is great for documenting a baseline image for our charts, screen for eye diseases, and improve our ability to view your internal retinal health. A dilated exam may still be recommended by the doctor if a more peripheral view of the retina is indicated. Since insurance only covers retinal photos after eye disease is discovered, the Retinal Imaging Exam is an out of pocket expense. **The fee is $22.00.**

☐ I want to have my retinal health evaluated with Retinal Imaging.

☐ I do not wish to have the Retinal Imaging Exam. I understand that I will still have a thorough eye exam with dilation.

Signature ____________________ **Date** ____________