APPOINTMENT DETAILS

DATE:	**APPT TIME:**	**CHECK-IN TIME:**
MED INS & COPAY:	**VIS INS & COPAY:**	
EXAM TYPE:	**DOCTOR:**	

PATIENT INFORMATION

Title First Name MI Last Name DOB

Address City State Zip

Home Phone Cell Phone E-Mail Address

If patient is not the Primary Insurance Subscriber, please provide the following:

Subscribers Name DOB Patients Relationship to Subscriber Employer

If Patient is under the age of 18, provide name of Guarantor:

PATIENT MEDICAL HISTORY

PRIMARY CARE DOCTOR **PHARMACY NAME, LOCATION & PHONE #**

Please List Current Medications:

_____

_____

_____

Allergies to Medications:

_____

_____

_____

Do you have a family medical history of:

☐ Cataracts ☐ Macular Degeneration ☐ Glaucoma ☐ Corneal Issues ☐ Retinal Issues ☐ Diabetes ☐ Other: _____

Have you ever been diagnosed with or are being treated for any of the following health issues:

☐ Cataracts	☐ Macular Degeneration	☐ Glaucoma	☐ Flashes/Floaters	☐ Oher Ocular Issues
☐ Allergies	☐ Rheumatoid Arthritis	☐ Lupus	☐ Heart Disease	☐ Hypertension
☐ Stroke	☐ Traumatic Head Injury	☐ Epilepsy	☐ Migraine Headaches	☐ Alzheimer's
☐ Parkinson's	☐ Multiple Sclerosis	☐ Diabetes	☐ Depression or Anxiety	☐ Leukemia
☐ Asthma	☐ Emphysema	☐ Anemia	☐ Thyroid Issues	☐ Cancer

☐ Other: _____

List any activities that may require special vision care:

_____

Do you currently wear Contact Lenses: ☐ YES ☐ NO **If YES, any special concerns or issues?** _____

PATIENT FLOW CHART & RECOMENDATIONS

NAME:	DOB:

FOR FRONT DESK USE

☐ Photo ID Scanned/Verified

☐ Patient Profile Updated/Saved

☐ HIPAA Signature on File

☐ Signature on INS file

☐ Insurance Plans/Auths Entered

☐ Insurance Cards Scanned/Saved

☐ Email Address Verified/Entered

☐ All Documents Scanned

ELIGIBILITY: ☐ EXAM ☐ LENS/CL ☐ FRAME

☐ ***PATIENT SIGNED FOR & RECIVIED A COPY OF THEIR CL RX – SCANNED & SAVED***

FOR TECHNICIAN USE

Test Performed:

☐ OCT ☐ Auto Refractor ☐ Fundus Photo

☐ Pressure Check ☐ Visual Fields: _____

DILATION TIME: _____

BLOOD SUGAR: _____ A1C: _____

BP: _____ HEIGHT: _____ WEIGHT: _____

NOTES:

FOR DOCTOR USE

PRIMARY PAIR: ☐1st Time RX ☐1st Time PAL

☐ Distance Only ☐ Full-Time Wear ☐ Near Only

☐ Detail Distance/Near ☐ WorkStation ☐ Suns

SECONDARY PAIR:

☐ Distance Only ☐ Full-Time Wear ☐ Near Only

☐ Detail Distance/Near ☐ WorkStation ☐ Suns

LENS TYPE:

☐ SV ☐ Bifocal ☐ Progressive ☐ EyeZen

☐ WorkStation ☐ OTHER: _____

MATERIAL:

☐ Hi-Index: _____ ☐ Polycarbonate ☐ TRIVEX

ENHANCEMENTS:

☐ NON-GLARE COATING ☐ TRANSITIONS

☐ BLUE LIGHT PROTECTION ☐ POLARIZED SUN

NOTES:

CONTACT LENS FITTING: ☐ Spherical ☐ Toric

☐ Multifocal ☐ Specialty Fit: _____

☐ Medically Necessary: _____

CONTACT LENS BRAND: _____

☐ NEW CL WEARER, NEEDS I&R Training Scheduled

☐ TRIALS NEED TO BE ORDERED

☐ RX FINALIZED, OK to Order if doing well

☐ ***RECOMMEND ANNUAL SUPPLY***

NEXT APPOINTMENT:

☐ _____DAYS 1 MONTH 3 MONTH 6 MONTH

REASON: _____

☐ CONTACT RE-CHECK: _____

☐ SEND PCP FORM to: _____

☐ PT SCHEDULED FOR: _____