Guardian: **Date:**

Name:

Address:

City, St: **Zip:**

Phone(H): W: C:

Date of Birth: **Sex:**

E-Mail:

Occupation:

Notify me by: ☐ Text ☐ Phone ☐ Email ☐ Mail

Who may we thank for referring you to our office?

☐ Friend ☐ Insurance ☐ Website ☐ Other...

Emergency Contact Name and Phone:

Approx. Date of Last Eye Exam:

The Vision Place
Sandra P. Palomino, OD, PA
16535 HUEBNER RD. STE 104
San Antonio, Texas 78248
210-764-1113
http://www.thevisionplace.net

Race
- American Indian or Alaska Native
- Asian
- Black or African-American
- Native Hawaiian or Other Pacific Islander
- Other Race
- Unknown/undetermined
- White

Ethnicity Hispanic or Latino Unknown
Not Hispanic or Latino

Language ☐ English ☐ French ☐ Russian ☐ Spanish ☐ Japanese ☐ Other...

Smoking
- 1 Current everyday smoker
- 2 Current some day smoker
- 3 Former smoker
- 4 Never smoker
- 5 Smoker, current status unknown
- 9 Unknown if ever smoked

What is the major purpose of this visit:

☐ Blur at Far
☐ Blur at Near
☐ Blur at Far & Near
☐ Itching
☐ Burning
☐ Redness
☐ Eye pain
☐ Eye strain
☐ Flashes/Floaters
☐ Loss of vision
☐ Double vision
☐ Sandy/Gritty
☐ Spots or shadows
☐ Diabetes eye check
☐ Medical eye check
☐ Other...

Which Eye? ☐ Right eye ☐ Left eye ☐ Both eyes

How long has it bothered you?

☐ Started today ☐ 1-2 weeks ☐ 3-6 months
☐ 1-2 days ☐ 2-4 weeks ☐ Over 6 months
☐ 3-7 days ☐ 1-3 months

Severity? ☐ Mild ☐ Moderate ☐ Severe

Getting Worse?

☐ Getting better ☐ Getting worse ☐ About the same

Current Prescription:

Glasses: Right
Left
Contacts: Right
Left

Medical Doctor(s):

Please note that insurance does NOT cover the Contact Lens Fitting Evaluation

Vision or Primary Insurance

Ins. Name:

Ins Number:

Relationship:

Insured:

Insured DOB: **Ins. Sex:** ○ M ○ F

Co-pay: **Materials:** ○ Y ○ N

Medical or Secondary Insurance

Ins. Name:

Ins Number:

Relationship:

Insured:

Insured DOB: **Ins. Sex:** ○ M ○ F

Co-pay: **Materials:** ○ Y ○ N

Participate in a flex spending account? ☐ Y ☐ N

Past Medical History

- ☐ Allergy
- ☐ Amblyopia
- ☐ Asthma
- ☐ Cancer
- ☐ Cataract
- ☐ Crossed Eyes
- ☐ Diabetes I
- ☐ Diabetes II
- ☐ Droopy Lid
- ☐ Ear
- ☐ Ear Problem
- ☐ Eye Infection
- ☐ Eye Injury
- ☐ Eye Surgery
- ☐ Gastrointestinal
- ☐ Glaucoma
- ☐ Heart disease
- ☐ High B.P.
- ☐ Keratoconus
- ☐ Kidney
- ☐ Lasik
- ☐ Lazy Eye
- ☐ Macular Degen.
- ☐ Migraine
- ☐ MS
- ☐ Psychological
- ☐ Sinus
- ☐ Thyroid
- ☐ Other...

Social History

- ☐ Computer
- ☐ Reading
- ☐ Student
- ☐ Music
- ☐ Skiing
- ☐ Golf
- ☐ Fishing
- ☐ Tennis
- ☐ Swim
- ☐ Bike
- ☐ Drug Abuse
- ☐ Alcohol Abuse
- ☐ No alcohol or drug abuse
- ☐ Other...

Current Medicines

Amount

Eye wear History

- ☐ Glasses
- ☐ Bifocals
- ☐ Trifocals
- ☐ No- line
- ☐ Soft Contacts
- ☐ Toric Soft
- ☐ Gas Perm
- ☐ Hard
- ☐ Monovision
- ☐ Disposable
- ☐ Overnight wear

Mark box if yes.

- ☐ Have you tried contact lenses?
- ☐ Not satisfied with the vision comfort of your contact lenses?
- ☐ Would prefer colored contacts?
- ☐ Do the lines and head tilting bother you with bifocals?

Family History

- ☐ Blindness
- ☐ Cataracts
- ☐ Crossed Eyes
- ☐ Color Blind
- ☐ Diabetes
- ☐ Kidney Disease
- ☐ Macular Degen.
- ☐ Retina Disease
- ☐ Retina Detach
- ☐ Heart Disease
- ☐ High B.P.
- ☐ Thyroid
- ☐ Glaucoma
- ☐ Cancer
- ☐ None
- ☐ Other...

Allergies

- ☐ None
- ☐ Penicillin
- ☐ Sulfa
- ☐ Eye drops
- ☐ Other...

Lifestyle Questions

Do you...(Check box if your answer is yes)

- ☐ Work at a computer often?
- ☐ Think you might benefit from thinner lenses?
- ☐ Would like to "test drive" the latest contact lenses?
- ☐ Spend time outdoors?
- ☐ Prefer not to wear your glasses at times?
- ☐ Want info. on Laser Vision Correction surgery?
- ☐ Have more than 1 pair of current Rx eyewear?

Our office requires payment at the time of service unless we "accept assignment" on your insurance. **You are responsible if your insurance doesn't pay.** We charge $2.00 every month on balances over 60 days. **Contact lens fit and follow up care is billed separately from your eye exam.** Your information is protected by our privacy policy.

I have received a copy of The Vision Place" Notice of Privacy Practices".

Remind me of my appointment by: ☐ Text

Signature_____ Date_____

Relationship to Patient: _____