

Patient Information

Last _____
 First _____ MI _____
 Street _____
 City _____ State _____
 Zip Code _____
 Home Phone _____
 Work Phone _____
 Patient's SSN _____
 Employer (or School) _____
 Occupation (or Grade) _____
 Spouse (or Parent's Name) _____
 Spouse (or Parent's Work) _____
 Date of Birth _____ Age _____
 Sex M F
 Email Address _____

What is the major purpose of this visit?

Any problems with your current contact lenses or glasses?

The mission of CIAMPA VISION CARE is to contribute to a lifetime of healthy vision, proving each patient with the highest quality vision care and consequent quality of life. We will seek continuing education to remain at the forefront of our profession and will offer the latest eye care technology, professional services, and products. The visual needs and wellness of each patient will always be our first priority. Everything we do shall communicate this.

Insurance Information

Please note that insurance does NOT cover the Contact Lens Follow-Up Evaluation.

Vision Insurance _____
 Subscriber Name _____
 Subscriber SSN _____
 Subscriber Birth Date _____
 Primary Medical Insurance _____
 Subscriber Name _____
 Subscriber SSN _____
 Subscriber Birth Date _____

Do you participate in a flex spending account?

Yes No

How will you settle your account today?

Cash Check Credit Card

Lifestyle Questions

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

- ..work at a computer? If yes, please complete computer questionnaire.
- ..think you might benefit from thinner, lighter lenses?
- ..have interest in a "test drive" of the latest contact lens designs
- ..spend time outdoors? How much? ___Hrs/week
- ..have prescription sunwear?
- ..prefer not to wear your glasses at times?
- ..want information on Laser Vision Correction surgery?
- ..have interest in a non-surgical approach to vision correction?
- ..have more than 1 pair of current Rx eyewear?
- ..have children?
- ..have family members in need of eyecare?

Have you ever experienced, been diagnosed or treated for any of the following?

- | | |
|--|--|
| <input type="checkbox"/> Blurry Vision | <input type="checkbox"/> Burning |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Corneal Abrasions |
| <input type="checkbox"/> Crossed eye/Eye turn | <input type="checkbox"/> Double Vision |
| <input type="checkbox"/> Eye Infections | <input type="checkbox"/> Eye Injury |
| <input type="checkbox"/> Flash of light | <input type="checkbox"/> Floaters/Spots |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Grittiness |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Iritis/Uveitis |
| <input type="checkbox"/> Itchiness | <input type="checkbox"/> Lazy Eye |
| <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Occasional dryness |
| <input type="checkbox"/> Retinal Detachment | <input type="checkbox"/> Sunlight Sensitivity |
| <input type="checkbox"/> Tearing | <input type="checkbox"/> Trouble seeing at night |
| <input type="checkbox"/> Uncomfortable glasses | |
| <input type="checkbox"/> Other eye disorders | |

The information in this confidential case history form is critical to the evaluation of your vision and health.

Patient Medical History

Name of Family Physician _____
 Town _____
 Date of Last Physical Check-up _____

CURRENT MEDICATIONS (Rx or Over the Counter)
 (List name of medications including eye drops, vitamins, & birth control pills) _____

Allergies to medications? Yes No
 If so, what medications? _____

Have you had any surgeries? Yes No
 Do you use cigarettes/tobacco, alcohol, or other substances? Yes No

Have you ever been diagnosed or treated for the following health problems? Yes No

- | | | |
|-----------------------------|--------------------------|--------------------------|
| Allergies | <input type="checkbox"/> | <input type="checkbox"/> |
| Arthritis | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood/Lymph | <input type="checkbox"/> | <input type="checkbox"/> |
| Bronchitis | <input type="checkbox"/> | <input type="checkbox"/> |
| Cancer | <input type="checkbox"/> | <input type="checkbox"/> |
| Cholesterol | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> |
| Digestive | <input type="checkbox"/> | <input type="checkbox"/> |
| Ears/Nose/Throat | <input type="checkbox"/> | <input type="checkbox"/> |
| Endocrine | <input type="checkbox"/> | <input type="checkbox"/> |
| Eczema/Rashes | <input type="checkbox"/> | <input type="checkbox"/> |
| Fatigue | <input type="checkbox"/> | <input type="checkbox"/> |
| Fingers | <input type="checkbox"/> | <input type="checkbox"/> |
| Genitourinary | <input type="checkbox"/> | <input type="checkbox"/> |
| High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> |
| Integumentary (Skin) | <input type="checkbox"/> | <input type="checkbox"/> |
| Kidney | <input type="checkbox"/> | <input type="checkbox"/> |
| Muscle/Bone | <input type="checkbox"/> | <input type="checkbox"/> |
| Neurological | <input type="checkbox"/> | <input type="checkbox"/> |
| Psychological | <input type="checkbox"/> | <input type="checkbox"/> |
| Respiratory | <input type="checkbox"/> | <input type="checkbox"/> |
| Sinus | <input type="checkbox"/> | <input type="checkbox"/> |
| Throat Infections | <input type="checkbox"/> | <input type="checkbox"/> |
| Thyroid | <input type="checkbox"/> | <input type="checkbox"/> |
| Unusual weight losses/gains | <input type="checkbox"/> | <input type="checkbox"/> |

Patient Eye History

Date of Last Eye Exam _____
 By Whom? _____

Have you ever tried contact lenses? Yes No

Do you currently wear contact lenses? Yes No
 What kind? _____
 Solutions used _____

Are you satisfied with the vision and comfort of your contact lenses? Yes No

Would you prefer clear contact lenses or colored contact lenses? Clear Colored

If you wear bifocals, do the lines or head tilting bother you? Yes No

Family Medical/Eye History (Check all that apply)

Is there a family medical history of any of the following:
 No Yes (Please check boxes)

- | | Relationship
(Mother's or Father's side) |
|----------------------|---|
| Blindness | <input type="checkbox"/> |
| Cataracts | <input type="checkbox"/> |
| Corneal Problems | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> |
| Glaucoma | <input type="checkbox"/> |
| Heart Disease | <input type="checkbox"/> |
| Lazy Eye | <input type="checkbox"/> |
| Macular Degeneration | <input type="checkbox"/> |
| Retinal Problems | <input type="checkbox"/> |

Please be advised if you are using insurance coverage for today's visit, this is a contract between you and your insurance company...not CIAMPA VISION CARE.

If your insurance company has not reimbursed our office in full within 60 (or 90) days, your credit card will be utilized and your insurance company will then pay you directly. (If by mistake your insurance company sends the payment check to us, we will of course sign over and forward the check directly to you.)

Please enter your credit card number and expiration date.
 CC#: _____
 Expiration Date: _____

Signature _____