Welcome to Briarwood Vision Center

Please answer the following questions to help us treat you better

Patient Information:

Name: Last______________________ First__________________ _Today's Date___________ Sex: M F
Address:______________________________________City:__________________ State: ____Zip_______
Phone: best number to contact you( )________________ Date of Birth:_______________ Age:______
Email address:______________________May we remind you of your annual exam via e-mail or text? (circle one)

Personal Information:

Have you been examined here before?_____ How did you hear about our office?____________________
Occupation_____________________What sports and hobbies do you enjoy?_________________________
How much of your day do you spend working on a computer?____________________________________
If you could, would you prefer not to wear glasses?__________Are you interested in Lasik?__________
Do you work in a hazardous environment that requires safety glasses?____________
Do you have prescription sunglasses?________________ Do you work or play outdoors?______________
How many hours a day do you spend driving?____
Do you drive frequently at dawn, dusk, or night?____
Do you drive frequently with the sun in your eyes?____
Do you know anyone else who could use our services? If so, whom?______________________________

Ocular and Medical History:

Reason for today's visit:______________________________________Date of last eye exam:_________
age of present glasses:________Have you ever worn contacts before?_____If not currently wearing contacts, are you interested in trying contacts?_______ what lens care system do you use?____________
Have your eyes ever been dilated……………………………… Yes No Date:____________________
Have you ever had an eye infection, disease, injury or surgery?. Yes No Explain:_________________
Are you sensitive to bright lights?.. Yes No
Do you see and flashes of light or floaters?................................ Yes No
Do you have trouble with night vision?...................................... Yes No
Are you experiencing any of the following with your eyes?(circle) Contact lens intolerance
Itchiness stinging burning dryness redness

If you have any of the above symptoms, please answer the following questions:
Have you been using artificial tears?__________ If yes, how often?______________________________
Have you tried many types of artificial tears? (i.e. visine, clear eyes, refresh, systane)________________
Do you feel like your use of artificial tears has increased over time?______________________________
Are dry eyes affecting your daily activities?____
Are your dry eyes getting worse?_______Are you satisfied with your current dry eye treatment?______
Are you ready to discuss treatment options for your dry eye with your doctor?______________________

Do you or any blood relatives have any of the following?

Diabetes…………………………………………………… Yes No Whom________type______
Date of Diagnosis________

High blood pressure:……………………………………… Yes No Whom_________________

High cholesterol………………………………………… Yes No Whom

Thyroid condition………………………………………….. Yes No Whom_________________

Cataracts………………………………………………… Yes No Whom_________________

Glaucoma……………………………………………….. Yes No Whom_________________

Retinal detachment or degeneration:…………………….. Yes No Whom_________________

Macular degeneration…………………………………… Yes No Whom_________________

Other eye conditions…………………………………………Yes No Explain________________

Who is your primary care physician?________________________________

How is your general health?____

Are you currently pregnant?________if so, how far along?_________

Do you smoke?__________________if so, how much?____________

Do you have any allergies?____

Please list any medications you are currently taking and their purpose:

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Financial Agreement: All charges for services and treatment will be paid upon completion of the appointment. All delinquent balances after 30 days will be turned over to a collections agency.

Insurance Billing: It is the policy of this office that all charges, regardless of insurance coverage, are ultimately the responsibility of the patient. Please understand that is for any reason payment is denied by your listed insurance company, we will seek compensation from the individual patient.

Co-payments: Your co-payment, deductibles, or charges over the maximum benefit amount allowed by the insurance company is due at the time of service.

I understand that my insurance company may not fully reimburse the doctor's fees for the services provided. Any benefits or pre-authorizations given to this office are not a guarantee of payment by the insurance company. Payment is dependent of eligibility at the time of service and all the terms and conditions of the plan. By my signature on this form, I agree that I am financially responsible for any balance owed for the doctor's services or materials which are not covered through my insurance.

Patient or Guardian's signature_____________________________________ Date _______________