VISIONComfort
EYE CARE

WELCOME FORM

Date__________

Patient's Name ________________________________ Date of Birth_____________
Last First M.I.

Social Security Number ___________________________ Sex: M___ F___

Address__________________________________ City________________State____Zip_____

Phone number:________________________ **E-Mail Address** ___________________________________

Do you give us permission to email you, your prescriptions through regular unencrypted email? YES NO

If married, name of spouse ____
Emergency Contact/Phone # ____

Occupation __________________________ Place of Employment ____________________

Referred by: Family Friend Internet Insurance Self (location)

OFFICE POLICY

Our opticians will work with you to select the best frames and lenses. There are no refunds unless it is requested on the same day of purchase since glasses are custom made. Once your order is placed there are no cancellations; if we make an exception to this policy, within 30 days of purchase, a 25% restocking fee will be applied. Vision Corner is not liable for any damage when using your own frame. If you decide to change your frame that you purchased here, you can replace the frame within 30 days from the date of dispense. It must be in original and undamaged condition. Eyemed Vision Insurance does not allow a frame change.

A pupillary distance measurement (PD) is and always has been considered part of the eyeglass fitting process conducted by our professional opticians for the purpose of making eyeglasses purchased at our office. This measurement is only for our office use and cannot be disclosed because of liability.

If you have insurance coverage, it is your responsibility to tell us before your exam. We cannot submit claims for you if you did not notify us about your insurance coverage before your exam. If you have insurance, we will submit these claims for you. All co-payments are due in full on initial visit. Certain charges will be assessed to the patient but will be billed to your major to your insurance provider. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_________________________________ __________________________ __________________
Responsible Party Signature Relationship Date

PAST HISTORY

Is there anything in your past history, family history, or social history which would help us care for you?

Past OCULAR conditions/complications or surgeries: ____________________

____

Self or Family History diseases, risk factors, hereditary, such as:

Condition				
Diabetes	Self	Family	Who?	____________________
Cholesterol	Self	Family	Who?	____________________
Hypertension	Self	Family	Who?	____________________
Thyroid	Self	Family	Who?	____________________
Glaucoma	Self	Family	Who?	____________________
Cataract	Self	Family	Who?	____________________
Macular Degeneration	Self	Family	Who?	____________________
Other:	Self	Family	Who?	____________________

Social History (past and current activities) Do you use any of the following products?

Tobacco: Yes No   Alcohol: Yes No   Recreational Drugs: Yes No

List family members currently living with you: ____________________

If female. Are you currently pregnant? Yes No

EYE HEALTH HISTORY

Date of last Vision exam: ________________ From Doctor: __________________ Date of present glasses: ________________

Did you have LASIK/PRK? Yes No Year:

Do you wear glasses? Yes No All the time Occasionally Reading Driving TV Computers

Do you wear contacts? Yes No Type: ______________________ Hours / Day ________________ Solution used: _______________________

MEDICATIONS (Systemic and Ocular)

List medications you are currently taking:	Reaons for taking each medication:
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________

ALLERGIES:

List allergies to medications or other substances

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REVIEW OF SYSTEMS: Do you have a problem CURRENTLY with…

Blurred vision	Y	N
Blindness	Y	N
Brown spot on eye	Y	N
Bulging eye	Y	N
Chronic eye infections	Y	N
Cloudy vision	Y	N
Crossed eyes	Y	N
Difficulty driving	Y	N
Difficulty reading	Y	N
Difficulty using computers	Y	N
Distorted vision	Y	N
Double vision	Y	N
Droopy eyelids	Y	N
Dry eyes	Y	N
Eye discharge	Y	N
Eye injury	Y	N
Eye pain	Y	N
Eye twitching	Y	N
Eyes burning	Y	N
Flashes	Y	N
Floaters	Y	N
Foreign body sensation	Y	N
Glare	Y	N
Halos around lights	Y	N
Headache	Y	N
Irritation	Y	N
Itchy eye	Y	N
Lid lesion	Y	N
Light sensitivity	Y	N
Photophobia	Y	N
Red eye	Y	N
Red spot on eye	Y	N
Retinal detachment	Y	N
Sandy or gritty feeling	Y	N
Swollen lids	Y	N
Tearing	Y	N
Temporary loss of vision	Y	N
Tired eyes	Y	N
Constitutional		
Fever	Y	N
Chills	Y	N
Weight loss	Y	N
Ear, Nose, Throat, Mouth		
Stuffy nose	Y	N
Ear ache	Y	N
Cough	Y	N
Dry mouth	Y	N
Cardiovascular	Y	N
Chronic ear infections	Y	N
Sinus problems	Y	N
Cardiovascular		
High blood pressure	Y	N
Rapid heart beat	Y	N
Vascular disease	Y	N
Heart pain	Y	N
Respiratory:		
Congestion	Y	N
Wheezing	Y	N
Shortness of breath	Y	N
Asthma	Y	N
Genitourinary:		
Burning on urination	Y	N
Urinary frequency	Y	N
Incontinence	Y	N
Genitals	Y	N
Kidney	Y	N
Musculoskeletal		
Joint pain	Y	N
Stiffness	Y	N
Arthritis	Y	N
Muscle pain	Y	N
Integumetary		
Rash	Y	N
Changing moles	Y	N
Skin	Y	N
Neurological		
Headache	Y	N
Seizure	Y	N
Stroke	Y	N
Paralysis	Y	N
Migraines	Y	N
Psychiatric		
Anxiety	Y	N
Depression	Y	N
Insomnia	Y	N
Nervous disorders	Y	N
Endocrine		
Diabetes	Y	N
Thyroid abnormalties	Y	N
Frequent urination	Y	N
Thirsty all the time	Y	N
Other glands	Y	N
Hematologic / Lymphatic		
Bleeding	Y	N
Anemia	Y	N
Swelling	Y	N

MEDICAL RETINA TESTING/IMAGING

The Optomap:

The Optomap Retinal Exam is a non-dilating camera that captures a digital image of the retina. It shows the doctor a view of the retina without dilation drops. It is highly recommended to see early signs of diseases such as retinal detachments and diabetic retinopathy. This instrument is recommended for all ages especially children.

The OCT:

Optical coherence tomography (OCT) uses light to take a ultrasound of your retina. Your optometrist can see all 10 layers of your retina. This instrument is state of the art in detecting early glaucoma, macular degeneration, optic nerve swelling and/or other eye diseases.

BOTH are HIGHLY recommended by our optometrists especially if you have diabetes, high blood pressure, over 50 years old, you have any family history of an eye disease or this is your child's first eye exam.

- ☐ Optomap Fee $39
- ☐ OCT Fee $39
- ☐ BOTH. Fee is $55.00 (highly recommended by Dr. Iqbal and Dr. Alvarado)*

Select one of the above and sign below to acknowledge that you are aware that you are responsible for the fee above.

X____

Contact Lens Exam Fee

The comprehensive eye exam you will receive today includes refraction (spectacle lens evaluation) and a thorough evaluation of the health of your eyes. Evaluating the fit, condition, and prescription of your current or future contact lenses is not included in the comprehensive eye exam. In order to render this service to you an additional fee will be charged. This fee is due the day services are rendered. The contact lens service fee includes up to 4 follow ups visits within 90 days if needed. The contact lens service fee is usually not covered by insurance; it will normally be an out-of-pocket expense. The contact lens service fee ranges from $95-$135.

- ❑ Yes, I understand my contacts lens fitting is a separate fee from my routine eye exam.
- ❑ No, I do not want a contact lens fitting

______________________________ ______________________

PRINT NAME **DATE**

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SIGNATURE

VISIONComfort
EYE CARE

Acknowledge of Receipt

8751 Hwy. 6 S. Ste. A
Houston, TX 77083
(281) 498-1381

I acknowledge that I have been given the following options related to communicating with Vision Comfort, its doctors, and staff members:

> I agree to allow Vision Comfort's doctors and staff to leave messages on my answering machine, answering service, or with an individual at my home or workplace that identifies the message as originating from Vision Comfort. I understand that clinical information will not be part of this message.
>
> I agree to allow Vision Comfort to send me marketing materials (i.e. recalls), clinical information concerning services, and/or products available at Vision Comfort. Such information will be mailed, emailed, or otherwise delivered in an envelope, postcard, or electronic communications method that may contain my name and that of Vision Comfort, an individual optician, or an optometrist providing care at Vision Comfort.

I acknowledge that I received a copy of Vision Comfort's Notice of Privacy Practices.

Patient Name: ______________________________

Signature: _________________________________ Date: ________________________

I agree to allow Vision Comfort's doctors and staff to disclose my private information including personal, financial, and medical information to the people listed below.

I agree to notify Vision Comfort in writing should this list need to be amended.

Name: _______________________ Relationship: ______________ DOB: ______________

Name: _______________________ Relationship: ______________ DOB: ______________

Name: _______________________ Relationship: ______________ DOB: ______________