VISIONComfort
EYE CARE

WELCOME BACK ESTABLISHED PATIENT

Patient's Name _____ Date of Birth_____

Any Change in Address: _____

E-Mail Address: _____ **Cell phone #:** _____

Do you give us permission to text or email you your prescriptions through regular unencrypted email? YES NO Circle the health conditions that apply to you today:

Diabetes Hypertension High Cholesterol Thyroid Cancer Glaucoma Cataract Macular Degeneration

Have you had ANY CHANGES to your medical or ocular history since your last visit? (ex. Cataract surgery, LASIK, new medications, new treatments, etc.) Please explain:_____

Are you experiencing any of the following? If any of these apply, you may need an office visit/medical eye evaluation today.

- ☐ **Double vision**
- ☐ **Droopy eyelids**
- ☐ **Dry eyes**
- ☐ **Eye discharge/Infection**
- ☐ **Eye injury**
- ☐ **Eye pain**
- ☐ **Eye twitching**
- ☐ **Floaters**
- ☐ **Flashes of light**
- ☐ **Blurred vision**
- ☐ **Blindness**
- ☐ **Brown spot on eye**
- ☐ **Cloudy vision**
- ☐ **Crossed eyes**
- ☐ **Difficulty driving or Glare**
- ☐ **Distorted vision**
- ☐ **Halos around lights**
- ☐ **Headache**
- ☐ **Irritation**
- ☐ **Itchy eye**
- ☐ **Lid lesion**
- ☐ **Light sensitivity/pain**
- ☐ **Red eye**
- ☐ **Foreign body sensation**

OFFICE POLICIES

Our opticians will work with you to select the best frames and lenses. All glasses orders are final sale. 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 35% restocking fee will be applied. Vision Comfort 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 pupil 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 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:_____ Date: _____

If patient under 18 - Print name of signing party _____ Relationship:_____