SPECIALTY Eyecare Group
a member of VISION SOURCE

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Adult Patient Intake Form

Patient's Legal Name: _____ DOB: _____ Last 4 of SSN# _____ Sex: M /F

Address: _____City: _____State: _____ Zip: _____

Home Ph: _____ Cell Ph: _____ E-mail: _____

Occupation/Grade: _____ Employer/School: _____

If married, Spouse's Name: _____ Occupation: _____

Preferred language: _____Race:_____Ethnicity:_____

Do you have children? If yes, please fill in below:

Name: _____ DOB: _____ Name: _____ DOB: _____

Name: _____ DOB: _____ Name: _____DOB: _____

How did you find out about us? _____Referred by: _____

(If Provider) Office name: _____Phone #:_____

Location of office: _____

Insurance Verification and Privacy Statement:

Vision Ins Co. Name: _____ Subscriber's Name: _____

Relationship to subscriber: Self/Spouse/Child Subscriber's ID/SSN# _____/_____DOB:_____

Medical Ins Co. Name: _____ Subscriber's Name: _____

Relationship to subscriber: Self/Spouse/Child Subscriber's ID #_____DOB: _____

MUST SIGN BOTH LINES BEFORE PROCEEDING TO APPOINTMENT

Authorization: I certify that I have read and answered the above information to the best of my ability. My signature below serves as a signature on file for billing and that I have been given an opportunity to review the HIPPA Privacy Act as it applies to my care with Specialty Eyecare Group.

Signature _____ **Date** _____

Insurance Coverage

In order to serve you better; please provide your insurance card(s) so we may make copies

In signing this statement I agree to be financially responsible for all charges. I understand that my insurance is not a substitute for payment and it is my responsibility to pay, in advance, the deductible, the co-pay and any other balance not paid by my insurance company. **I also understand that verification of my benefits is not a guarantee of payment.** Most insurance policies pay only a portion of the total fees. If you have questions about your coverage, please contact your insurance company. All accounts over 60 days will receive an interest charge of 1.5% per month (or 18% per year) on all unpaid balances.

I have had my insurance explained to me and have had an opportunity to ask questions. I understand that I am responsible for charges for services and products that are not covered by my insurance plan.

Signature _____ **Date** _____

Please review and complete:

Health History

Last Eye Exam On: _____ Doctor's Name: _____Phone# _____

Medical Doctor: _____ Clinic: _____ Phone# _____

Other Doctor: _____ Clinic: _____ Phone# _____

Medications (Prescribed and OTC) _____

Allergies (Medications):_____

Allergies (Seasonal/Other):_____

Developmental Delays? _____

Therapy/Tutoring? _____ Provider: _____

Therapy/Tutoring? _____ Provider: _____

Personal Eye Health History								
	Y	**N**		**Y**	**N**		**Y**	**N**
Full time glasses wear			White appearance in pupil			Frequent loss of place		
Glasses wear for distance only			Squinting/eye rubbing/blinking			Omits/Inserts/re-reads' letters or words		
Glasses wear for near only			Headaches			Poor reading comprehension		
Soft contact lens wear			Red/Itchy eyes			Confuses similar looking words		
Rigid contact lens wear			Blurry/double vision			Reversals after 1st grade		
Strabismus surgery			Crossed or Lazy eye			Smart in everything but school		
*If yes, Right eye			Head tilting/closing eye			Fatigue/frustration with homework		
*If yes, Left eye			Difficulty copying from board			Fatigue/frustration with reading		
Previous eye injuries			Poor handwriting, misaligns numbers			Difficulties with reading		
*If yes, Right eye			Inconsistent/poor sports performance			Difficulties with spelling		
*If yes, Left eye			Holds books closely			Difficulties with math		
Any loss of vision			Avoidance of near work			Is your child meeting their potentials		

Previous head trauma/injury? If yes, when? _____ Location (on head): _____

Sports/Hobbies/Activities: _____

What activities require protective eyewear? _____

Social History

Drinking: ***YES / NO*** Amount (Weekly): _____ Tobacco Use: ***YES / NO*** Amount (Weekly):_____

Smoking Status: Currently / Former / Heavy / Light / Never

Personal Health History								
Constitutional	***Y***	***N***	***Cardiovascular CON.***	***Y***	***N***	***Musculo CON.***	***Y***	***N***
Developmental Disabilities			Heart Disease			Muscular Dystrophy		
Cancer			Vascular Disease			Ankylosing Spondylitis		
Fatigue Syndrome			Congestive Heart Failure			Osteoporosis		
ENT	***Y***	***N***	***Respiratory***	***Y***	***N***	***Integumentary***	***Y***	***N***
Hearing Loss			Asthma			Eczema		
Sinusitis			Bronchitis/ Emphysema			Rosacea		
Dry Mouth			Chronic Obstruction			Psoriasis		
Laryngitis			Sleep Apnea			Herpes Simplex (cold sores)		
Neurological	***Y***	***N***	***Gastrointestinal***	***Y***	***N***	Herpes Zoster (shingles)		
Multiple Sclerosis			Crohn's Disease			***Endocrine***	***Y***	***N***
Epilepsy			Colitis			Type 1 Diabetes Mellitus		
Cerebral Palsy			Ulcer			Type 2 Diabetes Mellitus		
Tumor			Acid Reflux			Thyroid Dysfunction		
Stroke			Celiac Disease			Hormonal Dysfunction		
Migraine			***Genitourinary***	***Y***	***N***	***Hemotological/Lymphatic***	***Y***	***N***
Autism Spectrum Disorder			Kidney Disease			Anemia		
Psychological	***Y***	***N***	Prostate Disease/Cancer			Large-volume Blood Loss		
Depression			STD			Ulcer		
Attention Deficit			Benign Prostate Hypertrophy			Hypercholesteremia		
Anxiety Disorder			Pregnant/ Nursing			***Immune***	***Y***	***N***
Bipolar Disorder			***Musculo***	***Y***	***N***	Rheumatoid Arthrities		
Cardiovascular	***Y***	***N***	Arthritis: Osteo/ Rheumatoid			Lupus		
Hypertension			Fibromyalgia			Sjogren's Syndrome		
Stroke/CVA								

Other personal health history: _____

_____

_____

Family Medical and Ocular History										
Condition	**Y**	**N**	**Mother**	**Father**	**Sister**	**Brother**	**Mat. G-mother**	**Mat. G-father**	**Pat. G-mother**	**Pat. G-father**
Cancer:										
Diabetes Mellitus										
Diabetes Mellitus Type 1										
Diabetes Mellitus Type 2										
Hypertension										
Hyperthyroidism										
Hypothyroidism										
Thyroid Disorder										
Cataract										
Macular Degeneration										
Glaucoma										
Other:										

VISUAL SYMPTOMS CHECKLIST

Patient Name Age DOB Completed by

Eye Tracking, Teaming, Focusing	Never	Seldom	Occasionally	Frequently
Eye wanders or eye crosses				
Squinting, eye rubbing, blinking				
Blurred / Double vision				
Low blink rate				
Sensitivity to light				
Headaches with near work				
Burning, itchy, watery eyes				
Words run together while reading				
Print moves, jiggles, shimmers while reading				
Skips and/or repeats lines while reading				
Omits small words while reading				
Avoids near work or reading				
Holds reading too close				
Reading comprehension is low				
Difficulty keeping attention on reading				
Poor reader, but good understanding when read to				
Loses belonging / things				
Forgetful / poor memory				
Does not use time well				
Always says "I can't" before trying				
Attention or concentration difficulties				

Visual Analysis/Discrimination	Never	Seldom	Occasionally	Frequently
Confusion with likenesses or minor differences				
Over generalization when classifying objects				
Mistakes words with similar beginnings or endings				
Difficulty recognizing the same word repeated on the page				
Trouble writing letters or numbers & remembering them later				
Trouble learning the alphabet or recognizing words				
Difficulty understanding concept of size, magnitude, position				

Visual Figure-ground	Never	Seldom	Occasionally	Frequently
Difficulty moving on from certain details with written work				
Difficulty knowing what is important on a page				
Works slowly compared to peers				
Difficulty completing work				

Visual Closure	Never	Seldom	Occasionally	Frequently
Written work is incomplete				
Ignores visual details				
Poor understanding after "looking"				

Visual Memory and Sequencing	Never	Seldom	Occasionally	Frequently
Poor spelling skills				
Whispers to self during reading				
Difficulty seeing with the "mind's eye" what is read				
Trouble remembering what has been seen before				
Difficulty with math concepts				

VISUAL SYMPTOMS CHECKLIST

Visual Spatial	Never	Seldom	Occasionally	Frequently
Difficulty or slow to learn left from right				
Letter, number, or word reversals				
Poor coordination & balance or athletic performance				
Clumsiness, bumps into things, or knocks things over				
Good coordination but poor at catching/hitting a ball				
Poor walking/posture; leans back on heels, forward on toes or to side				
Perception of floor being tilted				
Limited peripheral vision				
Consistently stays to one side of the hallway or room				
Spatial disorientation				

Auditory-Visual Integration	Never	Seldom	Occasionally	Frequently
Poor spelling even after studying				
Trouble sounding out new words				
Poor letter to sound matching				
Needs directions repeated				
Mouth/lips move during silent reading				
Must learn new words over and over				
Reading speed is very, very slow				
Difficulty linking what is heard or seen				

Visual-Motor Integration	Never	Seldom	Occasionally	Frequently
Sloppy writing or drawing skills				
Erases excessively				
Trouble gripping pen/pencil				
Difficulty copying from the board				
Trouble finishing written assignments in time allowed				
Can give good answers aloud, but not in writing				
Seems to know the material, but does poorly on tests				
Difficulty writing numbers so they line up for math problems				

Visual-Vestibular	Never	Seldom	Occasionally	Frequently
Motion sickness				
Dizziness or nausea after visual movement				
Nausea while reading in a car				
Dizziness while watching minimal motion				
Dizziness while walking up/down stairs				
Feels overwhelmed by vision				
Poor sense of balance or equilibrium				
Headaches or eye pain when exposed to a bright light				