VISION REHABILITATION ASSOCIATES, P.C.

DOCTORS OF OPTOMETRY

Deana LaBrosse, O.D.
Michael Zost, O.D., FCOVD

Date Completed: _____

We are pleased to welcome you to our practice. The following information will aid us in providing the most complete care possible. Please take a few minutes to fill out this form as completely as you can. If you have questions, we will be glad to assist you.

PATIENT INFORMATION

Name _____

Address _____

City _____ State _____ Zip _____

Phone (Home) _____

Phone (Work) _____

Phone (Cell) _____

Email _____

Preferred Contact Method: ❒ Mail ❒ Phone ❒ Email

Sex ❒ M ❒ F Age _____ Birth date _____

SS# _____

Occupation _____ Employer _____

If a Student, School Name _____ Grade Enrolled in _____

To best monitor for ethnic related health and vision conditions, please check if any apply:

Black or African American	❒
American Indian or Alaska Native	❒
Asian, Asian American, or Pacific Islander	❒
Hispanic	❒
White	❒

Do you use tobacco? ❒ Yes ❒ No Do you use alcohol? ❒ Yes ❒ No

Are you pregnant or nursing? [Females Only] ❒ Yes ❒ No

REASON FOR TODAY'S VISIT

Date of last eye exam _____ Eye Doctor's Name _____

Were you referred by a doctor? ❒ Y ❒ N Doctor's name: _____

- ❒ Annual Check-up, Not Having Any Problems
- ❒ Need Stronger Prescription for Distance Tasks
- ❒ Need Bifocals, Reading Spectacles, or Glasses for Computer Use
- ❒ Replace Lost or Broken Spectacles
- ❒ Need a Back-up Pair of Spectacles or Sunglasses
- ❒ Need More Contact Lenses
- ❒ Would Like to Try Contact Lenses
- ❒ Trouble Using Eyes Comfortably
- ❒ Other _____

To get a better sense of how you use your eyes, are there any hobbies, sports, or other recreational activities you participate in on a regular basis?

_____

_____

Do you currently wear glasses? ❒ Yes ❒ No

❒ All the time ❒ Occasionally
❒ For Distance tasks ❒ For Near Tasks ❒ For Computer Use

Do you wear contact lenses? ❒ No ❒ Yes Brand if known _____

Pairs Left _____ Replacement Schedule _____

Hours Worn /Day _____ Solutions used _____

How old is the pair you have in your eyes today? _____

NOTICE OF PRIVACY PRACTICES

I acknowledge that I been offered a copy of Vision Rehabilitation Associates' Notice of Privacy Practices. Signature: _____ Date: _____

ASSIGNMENT OF INSURANCE BENEFITS / PAYMENT GUARANTEE

I hereby authorize payment to be made directly to Vision Rehabilitation Associates, P.C. for vision plan or insurance benefits payable to me for services or materials rendered that I have received from Vision Rehabilitation Associates, P.C.. I understand that I am financially responsible to Vision Rehabilitation Associates, P.C. for any non-covered services or materials, as defined by my insurer, which not paid by my primary or secondary insurer. I also understand that if my account balance becomes overdue and the overdue account is referred to a collection agency, a collection fee will be added the amount due and that I am financially responsible for the added costs also.

Signature: _____ Date: _____ Vision Rehabilitation Associates is not a provider for the following insurance company: _____

EYE / VISION CONCERNS

Place a "√" in any ❒ to indicate if you are experiencing any of the following.

- ❒ Blurred Vision – Distance
- ❒ Blurred Vision – Near
- ❒ Burning Eyes
- ❒ Crossed or Wandering Eye
- ❒ Crusty Eyelids
- ❒ Discharge from Eyes
- ❒ Dizzy Spells
- ❒ Double Vision
- ❒ Dry Eyes
- ❒ Eye Infection or Eye Injury
- ❒ Eye Strain, Fatigue, or Tiredness
- ❒ Fluctuating Vision
- ❒ Headaches
- ❒ Itching Eyes
- ❒ Light Sensitivity
- ❒ Poor Night Vision
- ❒ Red Eyes
- ❒ Seeing Flashes or Floaters, Halos or Spots
- ❒ Styes
- ❒ Temporary Loss of Vision
- ❒ Twitching Eyelid

Place a "√" in any ❒ to indicate if you or any blood relative has had any of the following problems (including parents, grandparents, uncle, aunts or siblings).

Cataracts	❒	❒
Eye Surgery	❒	❒
Glaucoma	❒	❒
Lazy Eye or Turned Eye	❒	❒
Macular Degeneration	❒	❒
Retinal Detachment	❒	❒
Vision Training	❒	❒

HEALTH HISTORY

Date of your last physical _____

Primary Care Physician's name _____

Phone Number _____

Place a "√" in any ❒ to indicate if you have had any of the following.
Also, place a "√" in any ❒ to indicate if a blood relative has had any of the following problems (including parents, grandparents, uncle, aunts or siblings).

	Yourself	Family Members
Anxiety	❒	❒
Arthritis	❒	❒
Asthma	❒	❒
Blindness	❒	❒
Cancer	❒	❒
Depression	❒	❒
Diabetes	❒	❒
Epilepsy	❒	❒
Head Injury	❒	❒
Heart Condition	❒	❒
High Blood Pressure	❒	❒
High Cholesterol	❒	❒
Migraine Headaches	❒	❒
Multiple Sclerosis	❒	❒
Sickle Cell or Trait	❒	❒
Shingles	❒	❒
Skin Disorder	❒	❒
Thyroid Condition	❒	❒

Other _____

Place a "√" in any ❒ to indicate if you have any sensitivities or allergies in the categories below.

- ❒ Drugs (Please List) _____
- ❒ Foods (Please List) _____
- ❒ Environmental / Seasonal (Please include which season bothers you most) _____

MEDICATIONS / VITAMINS / SUPPLEMENTS

Place a "√" in any ❒ to indicate if you use any prescribed or over-the-counter substances in the categories below.

- ❒ Eye Drops (Please List) _____
- ❒ Medications (Please List) _____
- ❒ Vitamins / Supplements (Please List) _____

— Thank You —