Patient Information Date: ___________________________

Title: (Circle One) Miss Mrs. Ms. Mr. Dr. Rev.

Name: ____
LAST FIRST MIDDLE (NAME YOU PREFER TO BE CALLED)

Date of Birth: ___________________________Age _________SS#____________________ Sex: M______F______

Mailing Address: ____

City _______________________________ State___________________________ Zip__________________________

Home Phone: ____________________ Cell Phone: _____________________ Work Phone: ____________________

E-mail ____

How would you like to be contacted: ❒Cell Phone ❒Work Phone ❒Home Phone ❒Text Message ❒ Email

Employment Status: ___________________________ Employer: ________________________________

If student – Full time or Part time? ________________ School: _______________________________

Occupation: _________________________________ Marital Status: _____________________________

Name of Spouse/Partner: _______________________ Name of Parent (If Child) _____________________

Emergency Contact: ___________________________ Relationship____________ Phone___________________

How did you hear about our office: ❒ Printed Advertisement, which one? _________________________________

❒ Website ❒ Phone Book ❒ Insurance Company ❒ Referred By: ____________________________________

PERSON RESPONSIBLE FOR PAYMENT ❒Self - same as above

Name: ____
LAST FIRST MIDDLE

Mailing Address: ____

City: __________________________________State____________Zip______________________________

Phone: Home _________________ Work: _________________Cell: ____________________

E-mail Address: _______________________________________

Insurance: (Primary/Medical) ____

Name of Insured: ____

Relationship with Insured: ❒Self ❒Spouse ❒Child ❒Other ________________

Subscriber ID #: ______________________________ Group #: ___________________________________

Is this plan through an employer? ❒YES ❒ NO Name of Employer ________________________________

To obtain insurance benefits and authorization, we are often asked for the subscriber's social security number and date of birth. SSN # ______-______-_______ Date of Birth: ________________________

Insurance: (Secondary/Vision) ____

Name of Insured: ____

Relationship with Insured: ❒Self ❒Spouse ❒Child ❒Other ________________

Subscriber ID #: ______________________________ Group #: ___________________________________

Is this plan through an employer? ❒YES ❒ NO Name of Employer ________________________________

To obtain insurance benefits and authorization, we are often asked for the subscriber's social security number and date of birth. SSN # ______-______-_______ Date of Birth: ________________________

Flex Spending Account ❒Yes ❒ No ***If you have more than two insurances, please let us know ***

LIFETIME FINANCIAL & PRIVACY AUTHORIZATION: We request your signature on file, in the event the office files insurance for you or for any office procedure. This clause applies to **all insurance carriers.** Jhall

_______ (Initial here) I hereby authorized release of any medical or incidental information necessary for medical benefit or to obtain payment for services and request that payments of benefits be made to the party who accepts assignment. I understand that I am financially responsible for all charges not paid by my insurance company. Payment for non-covered services is expected at time of visit. A copy of this authorization will remain on file for all future visits.

_______ (Initial here) NOTICE OF PRIVACY PRACTICES: A copy of our privacy policies is available on our website and at the front desk upon request. I acknowledge that I have been offered a copy of the Privacy Practices of Hillcrest Vision.
Please list persons with whom we may discuss your health/account information: _____________________________________

Signature____**Date**___________________________

Medical and Ocular History Form

Date of last medical exam: ______________________ Medical Doctor: ______________________________
Date of last eye exam: _______________________ Previous eye doctor: ______________________________
Do you wear contact lenses? Yes❒ No❒ Brand of Lens? _________________________ Solution?_________________
How often do you replace them? _______________ How often do you sleep in them? __________________________
Are you interested in contact lenses but have been told you couldn't wear them in the past? YES NO

Personal Medical History

Do you currently have or have ever had the following conditions, check those that apply.

General Health
❒Current Pregnancy or Nursing
❒Developmental Disability
❒Cancer – Type ______________
❒Tobacco Use
❒Alcohol Use
❒Drug Use

Allergic/Immunologic
❒Drug Allergy ________________
❒Environmental Allergy _________
____
❒Rheumatoid Arthritis

Cardiovascular
❒Hypertension/High Blood Pressure
❒Stroke
❒Heart Disease

Endocrine
❒Diabetes
❒Hypothyroid
❒Hyperthyroid

Neurological
❒Multiple Sclerosis
❒Epilepsy
❒Head Trauma
❒Headaches

Hematologic/Lymphatic
❒Anemia
❒Leukemia

Respiratory
❒Asthma
❒Emphysema
❒Frequent sinus infection

Eyes
❒Retinal Detachment
❒Glaucoma
❒Cataracts
❒Macular Degeneration
❒Lazy/Crossed Eye
❒Frequent Eye Infections
❒Eye Injury
❒Eye Allergies
❒Prism in glasses
❒Double Vision
❒Dry Eye

Dermatologic
❒Eczema
❒Rosacea
❒Psoriasis

Musculoskeletal
❒Muscular Dystrophy
❒Osteoarthritis
❒Ankylosing Spondylitis
❒Fibromyalgia

Psychiatric
❒Depression
❒Anxiety
❒Bipolar

Gastrointestinal
❒___________________________

Genitourinary
❒ __________________________

Ears, Nose, Throat
❒ __________________________

Infectious Disease
❒AIDS/HIV
❒Hepatitis
❒Tuberculosis
❒STDs ______________________

Other:
❒___________________________

Have you had any major injuries or surgeries and/or hospitalizations? Please list them.
____
____
____
____

Medications

Please list all you presently take:
____
____
____
____
____
____

Family History

Does any family member (parents, grandparents, siblings, and children) currently have or had any of the following conditions? Please write the relationship to you.

❒Blindness ____________________
❒Cataract ____________________
❒Crossed Eyes ____________________
❒Glaucoma ____________________
❒Macular Degeneration ____________________
❒Retinal Detachment ____________________
❒Retinal Disease ____________________
❒Cancer ____________________
❒Diabetes ____________________
❒Heart Disease ____________________
❒High Blood Pressure ____________________
❒Thyroid Disease ____________________

Another Tool for Preserving Eye Health

A new, highly sophisticated computerized instrument now allows us to take high quality digital images of the retina and other structures inside your eye. This procedure assists the doctor in early detection of many disorders, including glaucoma, diabetic retinopathy, macular degeneration, retinal detachments and many other vision threatening conditions. The images are stored in our computer and can be compared with images in the future, allowing us to observe even the smallest amount of change. The images can also be printed and shared with your family physician or specialists if necessary.

We strongly recommend that *all* patients have this procedure performed and it is especially important for people who have:

1. Headaches
2. See spots or flashes
3. Family history of diabetes
4. Family history of glaucoma
5. High blood pressure
6. High cholesterol
7. Reached the age of 40
8. Sudden vision change
9. Your vision is not correctable to 20/20
10. Never had the procedure previously
11. Have had retinal disorders such as a detachment, tear or floaters
12. Would like a “baseline” image for future comparisons.

Screening retinal photography is a valuable part of your eye exam especially if you fall into any of the above categories. There is an additional charge of $35.00.

Please check the appropriate line below and sign at the bottom.

_____ **I DO** want the procedure performed

_____ **I have chosen NOT** to have this test performed and will not hold Dr. Hall and/or Hillcrest Vision, OD, PA responsible for any disease or pathology that goes undetected due to the lack of diagnostic information that could have been obtained through this fundus photography.

__________________________ _______________
Signature Date

Vision Evaluation Form

To provide you with the best vision possible, we need to know a little more about you.
Please fill in the information below regarding your vision needs

---

Name ____ Date ______________________________

What is your reason for today's visit? ____

List your favorite leisure activities/hobbies – knowing this enables us to find the best vision correction for you:
____

Does your daily routine typically involve a computer? ❐ Yes ❐ No If so, how many hours? ________________

Please circle your answers below

1.	Are your eyes sensitive to sunlight?	YES	NO	
2.	Do you see halos around lights at night while driving?	YES	NO	
3.	Do you wear prescription glasses?	YES	NO	
4.	Do you have ultraviolet (UV) prescription eyewear?	YES	NO	
5.	Do you wear contact lenses?	YES	NO	
6.	Are you interested in learning about the latest technology available in contact lenses?	YES	NO	
7.	Are you planning on getting a contact lens evaluation today? (Additional fees apply)	YES	NO	MAYBE
8.	Are you interested in purchasing glasses today?	YES	NO	MAYBE

9. Do your eyes…(circle all that apply) Burn Water/Tear Itch Feel Dry

10. Do you see….(circle all that apply) Flashes of light Floating spots

11. If you currently wear glasses, what would you change about them? (Circle all that apply)

Style Comfort Thinner Lenses Less Glare

Sun Protection More Durable Invisible Bifocal

Computer User Questionnaire:

How far away is your computer screen ❐ Arms length ❐ Closer than arms length ❐ Farther than arms length

Do you notice any of these visual problems while at the computer?

❐ Headaches during or after working at the computer
❐ Burning Eyes
❐ Dry, tired or sore eyes
❐ Distance vision blurry when looking up from the computer
❐ Need to rest eyes frequently at work
❐ Halos around objects on the screen
❐ Text on computer screen begin to blur while working
❐ Need to tilt head/neck back to look through intermediate area of progressive lens

Many people experience a variety of symptoms after working at their computer for some period of time. If you answered yes to any of the questions above, there is a new type of eyewear that can dramatically improve your comfort level when working on a computer. Please make sure to discuss these issues with the doctor.

For Office Use Only: RTC: 1 2 3 4 5 6 12 days weeks months RE: DE MD GLAU EX EX/CL VF FP MED
REC: AR Trans Hi Poly CR HD PAL SV Comp DW CL: CK ORDER CALL