city of vision eye care

TECHNICIAN INFORMATION

Contact Lens Information

Does the patient wear contact lenses?	[do-you-wear-contacts]
Does the patient want a contact lens prescription and evaluation?	Yes - Service fee is $250 or VSP Copay No - Contact lens prescription is through a different provider or not needed
What CL solution does the patient use?	[contacts-solution]
Does the patient use backup glasses?	Yes No
Does the patient sleep in their contacts?	[contacts-sleep]
How often does the patient replace their contacts?	[contacts-replace]

Lifestyle Index

Headaches of any severity during the week:	1 2 3 4 5
Stiffness while reading or at computer:	1 2 3 4 5

Discomfort with computer/screen use:	1 2 3 4 5
Tired/Fatigued eyes:	1 2 3 4 5
Dry-Eye sensation while working at a computer:	1 2 3 4 5
Light sensitivity frequency:	1 2 3 4 5
Dizziness frequency:	1 2 3 4 5
Reading struggle Frequency:	1 2 3 4 5
Does the patient qualify for NeuroLens?	

Retinal Evaluation Question

Does the patient want optomap or dilation: OptoMap - Doctor Recommended. No side effects. (Often covered with $39 copay)
Dilation - Side effects include light sensitivity and blurry vision for 6-8 hours.

PATIENT INFO

Patient Name (Last First MI):	[last-name]	[first-name]		[middle-initial]
Nickname (if applicable):	[nick-name]	Choice of Pronoun:	[pronoun]	
Address:	[address]	Unit #	[apt-no]	
[city]	[state]	[zip-code]	SS#:	[social-security]
Email Address:	[email-682]			
Preferred Method of Contact:	[preferred-contact]			
Birthdate (MM/DD/YYYY):	[patient-bday-month]/[patient-bday-day]/[patient-bday-year]	**Occupation:**	[occupation]	
Birth Sex:	Male Female	**Employer/School Name:**	[employer]	
Marital Status:	[marital-status]	**Misc/Guardians:**	[parent-guardian]	

Billing Address (if different from above)

[billing-address] Unit #[billing-apt-no]		
[billing-city]	[billing-state]	[billing-zip-code]
Cell Phone	[billing-cell-phone]	
Home Phone:	[billing-home-phone]	

INSURANCE INFORMATION

Primary Vision

Does the Patient have Vision Insurace? No
Yes

Name of Insurance: [vision-insurer-name]
Insurance ID #: [vision-insurer-id]
Policy Group #: [vision-insurer-policy-group]

Is the patient the primary vision policy holder? Yes
No

Policy Holder Name: [vision-policy-holder]
Policy Holder Patient Relationship: Spouse
Child
Other

Policy Holder SSN: [vision-primary-ssn]
Policy Holder Birth Sex: Male
Female

Policy Holder DOB: [vision-policy-bday-month]/[vision-policy-bday-day]/[vision-policy-bday-year]
Policy Holder Occupation: [vision-primary-school-occupation]
Policy Holder Address: [vision-primary-address] #[vision-primary-apt-no]
[vision-primary-city], [vision-primary-state] [vision-primary-zip-code]
Policy Holder Phone: [vision-primary-phone]

Primary Medical

Does the Patient have Medical Insurace? No
Yes

Name of Insurance: [medical-insurer-name]
Insurance ID #: [medical-insurer-id]
Policy Group #: [medical-insurer-policy-group]

Is the patient the primary medical policy holder? Yes
No

Policy Holder Name: [medical-policy-holder]
Policy Holder Patient Relationship: Spouse
Child
Other

Policy Holder SSN: [medical-primary-ssn]
Policy Holder Birth Sex: Male
Female

Policy Holder DOB: [medical-primary-policy-bday-month]/[medical-primary-policy-bday-day]/[medical-primary-policy-bday-year]
Policy Holder Occupation: [medical-primary-school-occupation]
Policy Holder Address: [medical-primary-address] #[medical-primary-apt-no]
[medical-primary-city], [medical-primary-state] [medical-primary-zip-code]
Policy Holder Phone: [medical-primary-phone]

Secondary Medical

Does the Patient have Secondary Medical Insurace? Yes
No

Name of Insurance: [secondary-medical-insurer-name]
Insurance ID #: [secondary-medical-insurer-id]
Policy Group #: [secondary-medical-insurer-policy-group]

Is the patient the secondary medical policy holder? Yes
No

Policy Holder Name: [medical-secondary-policy-holder]
Policy Holder Patient Relationship: Spouse
Child
Other

Policy Holder SSN: [medical-secondary-ssn]
Policy Holder Birth Sex: Male
Female

Policy Holder DOB: [medical-secondary-policy-bday-month]/[medical-secondary-policy-bday-day]/[medical-secondary-policy-bday-year]
Policy Holder Occupation: [medical-secondary-school-occupation]
Policy Holder Address: [medical-secondary-address] #[medical-secondary-apt-no]
[medical-primary-city], [medical-secondary-state] [medical-secondary-zip-code]
Policy Holder Phone: [medical-secondary-phone]

MEDICAL INFORMATION PART 1

Review of Ocular Systems
Reason for Appointment: [reason-for-appointment]
Conditions:
[symptom-dropdown]
Ocular Surgeries or Trauma Reported: [eye-surgeries-trauma]

Patient Medical History
Medical Conditions Reported:
[medical-conditions]
Other: [other-medical-conditions]
Injuries, Surgeries or Hospitalizations: [injuries-surgeries]

Medications & Allergies
Prescriptions: [current-medications]

MEDICAL INFORMATION PART 2

Family Ocular History
Reported Eye History:
[family-eye-history]

Coordination of Care
Primary Care Physician: [primary-care-physician]
Primary Care Clinic: [primary-care-name]
Last Visit: [date-pcvisit]
Reason for Visit: [primary-care-reason]

Family Medical History
Medical Conditions Reported:
[family-medical-conditions]
Other: [family-other]

Other Eyecare Information
Previous Eye Care Facility: [eye-exam-last-doc]
Date of Last Eye Exam: [last-eye-exam]

Vitamins & Allergies
Vitamins/OTC: [current-vitamins]
Reported Drug Allergies: [drug-allergies]

Social History
Occupation: [occupation]
Hobbies: [textarea-hobbies]
Smoking Status: [smoking-status]
Race: [race-field] || Ethnicity: [ethnicity-field]
Preferred Language: [preferred-language]

Terms & Conditions Agreement

Patient has agreed to the terms and conditions: **[online-signature]** || Date: August 25, 2023