EYE EXPRESSIONS
OPTICAL

WELCOME!

Professional Attentive Eye Care Excellence.

1 Patient Information

Patient Name _____

Street Address _____

Apt. # _____

City/State/Zip _____

Home Phone (_____) _____

Work Phone (_____) _____

Cell Phone (_____) _____

Best Time & Place to Call _____

E-mail Address _____

Sex: ❑ M ❑ F Age _____ Birthdate _____

Occupation _____

Would it be OK to send reminders by text? ❑Yes ❑No

Whom may we thank for referring you to us? _____

Friend/Relative/Spouse_____ Dr. _____

Internet _____Website_____Social Media_____

2 Benefit Plan Information

Vision Benefit Plan _____

Member / Policy #_____ Group # _____

If covered by spouse, Name_____

SSN (last 4 digits) -_____ DOB _____

Medical Plan _____

Member / Policy #_____ Group # _____

Employer _____

IF PATIENT IS DEPENDENT OR CHILD COMPLETE BELOW

Responsible Person _____

Relationship to Patient _____

Address _____

City/State/Zip _____

Home Phone (_____) _____

Cell Phone (_____) _____

PRIMARY CARE PHYSICIAN-Dr._____

3 Eye Health History

Last Eye Exam_____/_____/_____

Last Eye Doctor _____

Do You Wear Glasses? ■Yes ■No

&Polarized Sunglasses? ■Yes ■No

Do You Wear Contacts? ■Yes ■No

What Kind? ☐ Daily ☐ Overnight

☐ Soft ☐ Toric ☐ Mutifocal

Interested *NEW BREAK-THROUGH* **COLORS Contacts?**

Ye☐ No☐

(available with or without vision correction)

ADVANCED VISION OPTIONS:

Correction beyond Glasses, such as LASIK or Contacts ❑Yes ❑No

Do You Experience Computer/ Tablet/Cell Eyestrain? ❑Yes ❑No

Hobbies:

❑Golf
❑Tennis
❑Boating
❑Fishing
❑Hiking
❑Bicycling
❑School Sports
❑Fitness
❑Other Interests

_____
_____
_____
_____

Please check the box below to indicate if you have any of the following: (with correction if worn)

Blurred Vision – Distance	■Yes	Glaucoma	❑Yes
Blurred Vision – Near	❑Yes	Headaches	❑Yes
Burning Eyes	❑Yes	Itching Eyes	❑Yes
Cataracts	❑Yes	Light Sensitive	❑Yes
Color Vision – Poor	❑Yes	Loss of Vision	❑Yes
Crossed Eyes	❑Yes	Eye Pain	❑Yes
Discharge From Eyes	❑Yes		
Double Vision	❑Yes	Night Vision – Poor	❑Yes
Dry Eyes/Gritty	❑Yes	Red Eyes	❑Yes
Eye Infection	❑Yes	Seeing Halos	❑Yes
Eye Injury	❑Yes	Seeing Flashes	❑Yes
Eye Strain	❑Yes	Temporary Loss of Vision	❑Yes
Fainting Spells/Blackouts	❑Yes	Twitching Eyelid	❑Yes
Floaters or Spots	❑Yes	Vision – Poor	❑Yes
Glare	❑Yes	Watering Eyes	❑Yes
IF CHILD:			
Doesn't enjoy reading	❑Yes	Homework takes longer	❑Yes
Poor writing skills	❑Yes	Short attention span	❑Yes

4 Medications

Please list **all medications** you are currently taking, including eye drops, and **for what medical reason**: IF NONE (circle)☐

_____

_____

_____

5 Allergies

Are you allergic to **any** medications? ❑Yes ❑No

If yes, please list: _____

_____

NOTE: If you have a printed list of current medications/ allergies, please provide to front desk so a copy can be made.

6 Medical Health History

PLEASE CHECK THE BOXES BELOW TO INDICATE **IF YOU** HAVE CURRENTLY OR HAVE A HISTORY OF ANY OF THE FOLLOWING:
ALSO CHECK THE BOX TO INDICATE IF A **BLOOD RELATIVE** HAS A HISTORY OF ANY THE FOLLOWING:
PLEASE NOTE: PROVIDING INCOMPLETE OR INCORRECT INFORMATION CAN BE DETRIMENTAL TO YOUR HEALTH.

	Yourself	Relative
AIDS/HIV	❑Yes	❑Yes
Arthritis	❑Yes	❑Yes
Artificial Heart Valve	❑Yes	❑Yes
Artificial Joints	❑Yes	❑Yes
Asthma	❑Yes	❑Yes
	❑Yes	❑Yes
Bleeding	❑Yes	❑Yes
Blindness	❑Yes	❑Yes
Cancer	❑Yes	❑Yes
Cataracts	❑Yes	❑Yes
Chemical Dependency	❑Yes	❑Yes
Cold Sores/Fever Blisters	❑Yes	❑Yes
Diabetes	❑Yes	❑Yes
Drug Sensitivity	❑Yes	❑Yes
Emphysema / COPD	❑Yes	❑Yes
Epilepsy	❑Yes	❑Yes
Eye Surgery	❑Yes	❑Yes
Glaucoma	❑Yes	❑Yes
Hay Fever	❑Yes	❑Yes
Heart Condition	❑Yes	❑Yes
Hepatitis (type _____)	❑Yes	❑Yes
High Blood Pressure	❑Yes	❑Yes

	Yourself	Relative
High Cholesterol	❑Yes	❑Yes
Kidney Disease	❑Yes	❑Yes
Lazy Eye	❑Yes	❑Yes
Lupus	❑Yes	❑Yes
Macular Degeneration	❑Yes	❑Yes
Migraine Headaches	❑Yes	❑Yes
Pacemaker	❑Yes	❑Yes
Poor Color Vision	❑Yes	❑Yes
Retinal Disease	❑Yes	❑Yes
Rheumatic Disease/Fever	❑Yes	❑Yes
Shingles	❑Yes	❑Yes
	❑Yes	❑Yes
Skin Conditions	❑Yes	❑Yes
Stroke	❑Yes	❑Yes
Thyroid Conditions	❑Yes	❑Yes
Tuberculosis	❑Yes	❑Yes

Other _____
_____
Are you pregnant? ❑Yes ❑No
Number of children: _____
Tobacco Use ..... ❑No ..... ❑Occasional..... ❑Frequent
Alcohol Use ..... ❑No ..... ❑Occasional..... ❑Frequent

7

Expectations/Reason(s) For Today's Visit: _____
_____
_____

8 Authorization

I hereby certify that I have read, understood and answered the above questions accurately to the best of my knowledge. I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my dependent in order for any third party payor to pay directly to **Dr. Michael Nodland**, any insurance benefits otherwise payable to me. I understand that I am financially responsible for all charges, whether or not paid by my insurance carrier or vision benefit plan, rendered on my behalf or my dependents. I agree to pay a minimum collection fee of $30.00 and any applicable collection costs and/or attorneys' fees if I do not satisfy payment for services rendered. I authorize the use of this signature on all insurance and/or benefit plan submissions made in my behalf.

X _____ _____ /_____ /_____
Signature of Patient or Responsible Person — Date

_____
Relationship to Patient if Dependent or Minor Child

9 Financial Arrangements

For your convenience we offer the following methods of payment. Please check the option you prefer :

❑Cash ❑Debit ❑AMEX

❑Visa ❑MasterCard ❑Discover

Payment in full is due today for any and all professional fees and/or applicable products.
SORRY WE CANNOT ACCEPT CHECKS

Thank You!

Dr. Michael Nodland would like to take this opportunity to thank you for trusting us as your eye care professionals. As we be-lieve that ***CLEAR VISION BEGINS WITH HEALTHY EYES***, a lifetime of preserving your precious eyesight is our primary concern.

We Welcome New Patients & Appreciate Your Kind Referrals!