

WELCOME TO OUR OFFICE – Vision Care Grayslake – Charlotte F. Nielsen, O.D.

**PATIENT INFORMATION**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_  
Street Address: \_\_\_\_\_ City, State, Zip \_\_\_\_\_  
Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Cell Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  Text OK Email address: \_\_\_\_\_  
Sex:  Male  Female Birth Date \_\_\_/\_\_\_/\_\_\_ Patient's SSN: \_\_\_\_\_  Married  Single  
Employer (CHILD -School): \_\_\_\_\_ Occupation (CHILD -Grade): \_\_\_\_\_ Race: \_\_\_\_\_  
Who referred you to our office? Name: \_\_\_\_\_ Or how did you choose our office? \_\_\_\_\_

**RESPONSIBLE PARTY/PARENT**  **SAME AS ABOVE**

Name: \_\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Birth Date \_\_\_/\_\_\_/\_\_\_  
Address:  Same as Patient Or: \_\_\_\_\_  
Home Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Relationship to patient:  Self  Spouse  Parent  Other: \_\_\_\_\_

**INSURANCE INFORMATION**

EYECARE PLAN: \_\_\_\_\_  
Insured's Name: \_\_\_\_\_ Birth Date \_\_\_/\_\_\_/\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Employer: \_\_\_\_\_ Relationship to patient:  Self  Spouse  Parent  Other: \_\_\_\_\_  
PRIMARY MEDICAL INSURANCE: \_\_\_\_\_  
Insured's Name: \_\_\_\_\_ Birth Date \_\_\_/\_\_\_/\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Employer: \_\_\_\_\_ Relationship to patient:  Self  Spouse  Parent  Other: \_\_\_\_\_

\*\*\* I authorize Vision Care Grayslake to release any information to my insurance company for payment purposes. I am responsible for any unpaid balance.

\_\_\_\_\_  
Patient's (or Guardian's) signature      Date

\*\*\* I acknowledge I have been directed to a copy of Dr. Charlotte Nielsen's Notice of Privacy Practices.

\_\_\_\_\_  
Patient's (or Guardian's) signature      Date

\*\*\*FOR MINORS: I authorize Vision Care Grayslake to treat my child.

\_\_\_\_\_  
Guardian's signature      Date

## PATIENT EYE HISTORY

Reason for today's visit: \_\_\_\_\_

Date of last eye exam: \_\_\_\_\_

Are you interested in  Contact Lenses  Glasses, today?

Have you ever tried contact lenses?  Yes  No

Do you currently wear contact lenses?  Yes  No

What kind? \_\_\_\_\_ How Long? \_\_\_\_\_ Solution Used? \_\_\_\_\_

Have YOU ever experienced, been diagnosed or treated for any of the following? (Please Circle)

Blurry Vision/Eyestrain	Cataracts	Dry Eyes	Double Vision	Eye Infections
Eye Injury/Surgery	Flashes of light	Floaters/Spots	Glaucoma	Headaches
Iritis/Uveitis	Itchiness	Lazy Eye	Macular Degeneration	
Retinal Detachment	Sunlight Sensitivity	Tearing	Trouble at night	
Other eye disorders _____				

## PATIENT MEDICAL HISTORY

Physician's Name: \_\_\_\_\_ Address: \_\_\_\_\_

**CURRENT MEDICATIONS (Rx or Over the Counter):** List name of medication including eye drops, vitamins & birth control:

\_\_\_\_\_

Any allergies to medications?  Yes  No If yes, please list: \_\_\_\_\_

Do you smoke?  Yes  No

Have you ever been diagnosed or treated for the following health problems? (Please circle)

Allergies	Arthritis	Cancer	Cataracts	Cholesterol
Glaucoma	Diabetes	Thyroid	Lazy Eye	Macular Degeneration
Retinal Problems	Neurological Issues	High Blood Pressure		

## FAMILY MEDICAL/EYE HISTORY (Circle all that apply)

Blindness      Cataracts      Diabetes      Glaucoma      Macular Degeneration

## LIFESTYLE QUESTIONS

Do you... (Check all that apply)

- work at a computer?
- have prescription sunglasses?
- spend time outdoors? How many hrs/week? \_\_\_\_\_
- work on crafts or hobbies?
- have children?
- have family members in need of eyecare?