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?**