bright eyes VISION CLINIC
ADULT & PEDIATRIC VISION CARE
NEURO VISION REHAB CENTER

Patient intake and insurance information

1. **Please enter your information below. Please note, it helps our systems communicate most efficiently if your name, birth date, and email address match your electronic health record. If you have a question about what information we have on file, please call or text us at 763-241-1090.**

Patient First Name: _____ Middle Initials: _____ Last Name: _____ Preferred Name (Nickname) _____

Date of Birth: _____ Sex: ○ Female ○ Male Patient Mailing Address: _____

City: _____ State: _____ Zip Code: _____ Mobile Phone: _____

Home Phone: _____ Work Phone: _____ Email: _____ Preferred contact method:
○ Mobile Phone
○ Home Phone
○ Work Phone

Marital Status:
○ Single ○ Married
○ Domestic Partner
○ Separated ○ Divorced
○ Widowed

Spouse/Partner Name (if applicable): _____ Spouse/Partner Phone (if applicable): _____

Name of Employer or School (if applicable) _____ Occupation or grade (if applicable) _____ Employer's Phone Number (if applicable) _____

Parent or Guardian Phone (if different from above): _____ Parent or Guardian (if applicable) _____

Account Guarantor (please specify if different than patient or patient's parent or guardian listed above) _____

Emergency Contact _____ Emergency Contact's Phone Number _____ Relationship to Emergency Contact: _____

Add Any Additional Contact Information You Feel Is Important (not required): _____

2. Race(s):

- ○ All Other Races
- ○ American Indian or Alaska Native
- ○ Asian
- ○ Black or African American
- ○ Native Hawaiian or Other Pacific Islander
- ○ White
- ○ Declined

3. Primary Language:

- ○ English
- ○ Spanish
- ○ Other
- ○ Declined

4. If you listed your primary language as "other," what is your primary language?

_____

5. Medical Insurance?

- ○ Yes
- ○ No

6. Primary Medical Insurance

Insurance Company _____ Member ID / Policy # _____ Group Number _____

Patient Relationship to Insured
○ Self ○ Spouse ○ Child ○ Other

Insured Name (if not Self) _____ Insured Phone # _____ Insured Date of Birth _____ Insured Gender ○ Female ○ Male

Insured Mailing Address _____ Insured City _____ Insured State _____ Zip Code _____

Insured SSN
_____

7. Secondary Medical Insurance?

- ○ Yes
- ○ No

8. Secondary Medical Insurance

Secondary Medical Insurance Company _____ Member ID / Policy # _____ Group Number _____

Patient Relationship to Insured
○ Self ○ Spouse ○ Child ○ Other

Insured Name _____ Insured Phone # _____ Insured Date of Birth _____ Insured Gender ○ Female ○ Male

Insured Street Address | Insured City | Insured State | Zip Code

Insured SSN

9. Do you have a vision Plan?

- ○ Yes
- ○ No

10. Primary Vision Plan

Primary Vision Insurance Company | Member ID / Policy #/Unique ID | Group Number (if applicable)

Patient Relationship to Insured
○ Self ○ Spouse ○ Child ○ Other

Insured SSN

Insured Name (if not self) | Insured Phone # | Insured Date of Birth | Insured Gender
○ Female ○ Male

Insured Street Address | Insured City | Insured State | Zip Code

11. Do you have a Secondary Vision Plan?

- ○ Yes
- ○ No

12. Secondary Vision Plan

Secondary Insurance Company | Member ID / Policy # | Group Number

Patient Relationship to Insured
○ Self ○ Spouse ○ Child ○ Other

Insured Name | Insured Phone # | Insured Date of Birth | Insured Gender
○ Female ○ Male

Insured Street Address | Insured City | Insured State | Zip Code

Insured SSN

13. Do you have Medicare?

- ○ Yes
- ○ No
- ○ Unknown

14. Insurance Cards

Please upload pictures of the front and back of the cards.

15. Is this visit related to a work or auto accident?

- ○ No
- ○ Auto accident
- ○ Workers compensation

16. Date of injury

If auto, what state did the accident occur?

Name of insurance company

Claim Number

Adjuster's name

Adjuster's fax number

Adjuster's phone number

Adjuster's email

Do you have an attorney?

☐ No ☐ Yes

Name of attorney

Attorney phone

17. Name of primary care physician and name/location of the clinic

18. Preferred pharmacy and location

Reason For Visit

19. What brings you in for an examination today?

Reason for visit today:

Date and location of last eye exam:

Current contact lens brand (if applicable):

Do you wear glasses?
○ Yes ○ No

Are you interested in a contact lens evaluation today?
○ Yes ○ No

20. If you currently wear contact lenses, please upload a picture of your boxes / packs below. Please be sure to upload pictures of the front and sides of boxes, so that all numbers are included.

21. Do you having any of the following vision concerns?

	Yes	No
Blurred vision at distance		
Blurred vision at near		
Bothersome night glare		
Eye dryness		
Watery eyes		
Flashes		
Floaters		
Eye strain		

22. Are you having any of the following concerns?

	Yes	No
Double vision at distance		
Double vision at near		
Dizziness		
Light sensitivity indoors		
Light sensitivity outdoors with sunglasses		
Loss of Place when reading:		

23. Do you experience headaches?

○ Yes ○ No

If yes, where on your head are the headaches? ie. right or left side? eye brow area? back of head?

If yes, how frequent are your headaches?

_____

If yes, on a scale of 1 to 10, with 10 being the worst, how severe are your headaches?

_____

24. Are you currently receiving any therapies?

☐ No

☐ Occupational therapy

☐ Physical therapy

_____ _____ _____

☐ Speech therapy

☐ Other:

_____ _____

Personal Eye Health History

25. Are you having any of the following eye concerns?

	Yes	No
Redness?		
Burning?		
Itching?		
Tearing?		
Discharge?		

26. Do you having any of the following vision concerns?

	Yes	No
Eye pain		
Poor night vision		
Total loss of vision		

27. **Mark all that apply to your personal eye history.**

- ☐ Glaucoma
- ☐ Glaucoma suspect
- ☐ Cataracts
- ☐ Macular Degeneration (AMD)
- ☐ Surgery of eyes
- ☐ None
- ☐ Patching
- ☐ Iritis or Uveitis
- ☐ Strabismus (eye turn)
- ☐ Amblyopia (reduced vision usually in one eye)
- ☐ Retinal degeneration/hole/detachment
- ☐ Retinal hole
- ☐ Retinal detachment
- ☐ Keratoconus
- ☐ Injury to eyes
- ☐ Other:

Social History

28. **Do you:**

	Yes	No
Drink alcohol?	Yes	No
Use tobacco?	Yes	No
E-cigarette or vaping use?	Yes	No
Substance use?	Yes	No

29. **Smoking Status, mark all that apply:**

- ☐ Current every day smoker
- ☐ Heavy tobacco smoker
- ☐ Smoker, current status unknown
- ☐ Current some day smoker
- ☐ Light tobacco smoker
- ☐ Unknown if ever smoked
- ☐ Former smoker, specify year quit
- ☐ Never smoker

Family Health History (including parents, siblings, and children)

30. **Does anyone in your family (parent, sibling or child) history of:**

	Yes	No	If yes, who? (i.e. paternal/maternal grandparent)	Unknown
Cancer	Yes	No		Unknown
Diabetes	Yes	No		Unknown
Hypertension	Yes	No		Unknown
Amblyopia (reduced vision usually in one eye)	Yes	No		Unknown
Macular Degeneration	Yes	No		Unknown
Cataract	Yes	No		Unknown
Glaucoma	Yes	No		Unknown
Strabismus (eye turn)	Yes	No		Unknown

Medication and Allergy History

31. **Do you use prescription medication or take any non-prescription supplements or vitamins?**

- ○ Yes
- ○ No
- ○ Unknown

32. **Please list any medications, vitamins or supplements you take, including dose and frequency if known. Alternatively, in the next question, you may upload a medication list.**

	Name of medication or supplement	Dosage	Frequency (ie. once a day)
1.			
2.			
3.			
4.			

33. **Upload a medication list (optional).**

34. **Do you have any environmental allergies?**

- ○ Yes
- ○ No
- ○ Unknown

35. **Do you have a latex sensitivity or allergy?**

- ○ Yes
- ○ No
- ○ Unknown

36. **Are you allergic to any medications or other substances?**

- ○ Yes
- ○ No
- ○ Unknown

37. **Please list any medications or other substances you are allergic to or suspect you are allergic to:**

_____

_____

_____

_____

Personal Medical History

Please mark any of the following that apply to you and your health history.

38. **Do you have diabetes or pre-diabetes?**

- ○ Yes
- ○ No

39. **Diabetes can greatly impact your vision both temporarily and permanently. This information will help maximize your vision.**

Type of diabetes:

☐ Type 1 ☐ Type 2 ☐ Other

Year diagnosed with diabetes?

_____

How often do you check your blood glucose?

_____

What is your normal range of blood glucose?

_____

What was your last A1C and on what date?

_____

What doctor manages your diabetes? We will send them a report to coordinate your care.

_____

Add any applicable info here:

_____

40. **Constitutional. Check all that apply and note the details/date of diagnosis where applicable.**

☐ Development Disability	☐ Cancer	☐ Fever
_____	_____	_____
☐ Fatigue	☐ Other	☐ No Problems
_____	_____	_____

41. Ear, Nose, Throat. Check all that apply and note the details/date of diagnosis where applicable.

- ☐ Hearing Loss _____
- ☐ Sinusitis _____
- ☐ Dry Mouth _____
- ☐ Laryngitis _____
- ☐ Other _____
- ☐ No Problems _____

42. Neurological.Check all that apply and note the details/date of diagnosis where applicable.

- ☐ Multiple Sclerosis _____
- ☐ Epilepsy _____
- ☐ Alzheimer's _____
- ☐ Parkinson's _____
- ☐ Cerebral Palsy _____
- ☐ Tumor _____
- ☐ Stroke/CVA _____
- ☐ Migraine _____
- ☐ Autism Spectrum Disorder _____
- ☐ Lyme or tick bite _____
- ☐ Other _____
- ☐ No Problems _____

43. Psychiatric. Check all that apply and note the details/date of diagnosis where applicable.

- ☐ Depression _____
- ☐ Attention Deficit _____
- ☐ Anxiety Disorder _____
- ☐ Bipoloar Disorder _____
- ☐ Other _____
- ☐ No Problems _____

44. Cardiovascular. Check all that apply and note the details/date of diagnosis where applicable.

- ☐ Hypertension _____
- ☐ Stroke/CVA _____
- ☐ Heart Disease _____
- ☐ Vascular Disease _____
- ☐ Congestive Heart Failure _____
- ☐ Other _____
- ☐ No Problems _____

45. Respiratory. Check all that apply and note the details/date of diagnosis where applicable.

- ☐ Cigarette Smoker _____
- ☐ Asthma _____
- ☐ Bronchitis _____
- ☐ Emphysema _____
- ☐ Chronic Obstruction (COPD) _____
- ☐ Sleep Apnea _____
- ☐ Other _____
- ☐ No Problems _____

46. **Gastrointestinal. Check all that apply and note the details/date of diagnosis where applicable.**

- ☐ Crohn's _____
- ☐ Colitis _____
- ☐ Ulcer _____
- ☐ Acid Reflux _____
- ☐ Celiac Disease _____
- ☐ Other _____
- ☐ No Problems _____

47. **Genitourinary. Check all that apply and note the details/date of diagnosis where applicable.**

- ☐ Kidney Disease _____
- ☐ Prostate disease/Cancer _____
- ☐ STD - herpetic/chlamydia _____
- ☐ Benign Prostrate Hypertrophy _____
- ☐ Currently Pregnant _____
- ☐ Currently Nursing _____
- ☐ Other _____
- ☐ No Problems _____

48. **Musculoskeletal. Check all that apply and note the details/date of diagnosis where applicable.**

- ☐ Osteoarthritis _____
- ☐ Arthritis _____
- ☐ Fibromyalgia _____
- ☐ Muscular Dystrophy _____
- ☐ Ankylosing Spondylitis _____
- ☐ Osteoporosis _____
- ☐ Gout _____
- ☐ Other _____
- ☐ No Problems _____

49. **Integumentary/Skin. Check all that apply and note the details/date of diagnosis where applicable.**

- ☐ Eczema _____
- ☐ Rosacea _____
- ☐ Psoriasis _____
- ☐ Herpes Simplex/Cold Sores _____
- ☐ Herpes Zoster/Shingles _____
- ☐ Other _____
- ☐ Cancer _____
- ☐ No Problems _____

50. **Endocrine. Check all that apply and note the details/date of diagnosis where applicable.**

- ☐ Type 2 Diabetes _____
- ☐ Type 1 Diabetes _____
- ☐ Thyroid dysfunction _____
- ☐ Hormonal dysfunction _____
- ☐ Other _____
- ☐ No Problems _____

51. **Hematologic/Lymphatic. Check all that apply and note the details/date of diagnosis where applicable.**

- ☐ Anemia _____
- ☐ Large volume blood loss _____
- ☐ Leukemia _____
- ☐ High cholesterol _____
- ☐ Other _____
- ☐ No problems _____

52. **Allergy/Immunologic. Check all that apply and note the details/date of diagnosis where applicable.**

- ☐ Drug Allergies _____
- ☐ Environmental/Seasonal _____
- ☐ Lupus _____
- ☐ Rheumatoid Arthritis _____
- ☐ Sjogren's Syndrome _____
- ☐ Other _____
- ☐ No Problems _____

53. **Have you had a concussion, brain injury or car accident? If yes, please provide details and date(s).**

- ○ Yes
- ○ No

54. **Please list other conditions, surgeries, or problems you feel are significant (optional):**

_____

Employment/Education Information (If applicable)

55. What is your occupation? (if a student, which grade or major of study?)

_____

How many hours daily are spent on a smart phone, tablet or computer?

_____

How many hours are spent reading books?

_____

Add any applicable information you would like to share:

_____

Providers

56. **It is often beneficial for us to discuss examination results and exchange information with other professionals involved in your care. Would you like us to share your records with any providers today?**

- ○ Yes
- ○ No

57. Please list providers that should receive information about your vision care:

Name of physician and name/location of the clinic and phone/fax number