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: _____ Gender: ○ 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. Were you referred to our care by another provider?

_____

_____

_____

_____

20. Type of injury/accident(s): Please add dates for each injury

☐ Motor vehicle _____

☐ Fall _____

☐ Blow to head _____

☐ Industrial or work-related accident _____

☐ Medication-related _____

☐ Drug abuse _____

☐ Poison or toxic substance _____

☐ Carbon monoxide _____

☐ Anoxic/lack of oxygen _____

☐ Stroke/CVA _____

☐ Aneurysm _____

☐ Hemorrhage _____

☐ Lyme or tick-related _____

☐ Other _____

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

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

22. 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?

_____

23. Are you having any of the following concerns?

	Yes	No	Had prior to injury
Dizziness			
Light sensitivity indoors			
Light sensitivity outdoors with sunglasses			
Double vision at distance			
Double vision at near			
Total loss of vision:			
Loss of Place when reading			

24. Are you currently receiving any therapies?

☐ No
_____
☐ Speech therapy
_____
☐ Occupational therapy
_____
☐ Other:
_____
☐ Physical therapy
_____

Personal Eye Health History

25. 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

26. **Do you:**

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

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

☐ Current every day smoker _____

☐ Current some day smoker _____

☐ Former smoker, specify year quit _____

☐ Heavy tobacco smoker _____

☐ Light tobacco smoker _____

☐ Never smoker _____

☐ Smoker, current status unknown _____

☐ Unknown if ever smoked _____

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

28. **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

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

○ Yes ○ No ○ Unknown

30. 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.			
5.			
6.			

31. Upload a medication list (optional).

32. Are you allergic to any medications or other substances?

- ○ Yes
- ○ No
- ○ Unknown

33. Do you have any environmental allergies?

- ○ Yes
- ○ No
- ○ Unknown

34. Do you have a latex sensitivity or allergy?

- ○ Yes
- ○ No
- ○ Unknown

35. 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.

36. Do you have diabetes or pre-diabetes?

- ○ Yes
- ○ No

37. 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:

_____

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

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

39. 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
_____	_____	_____

40. 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
_____	_____	_____

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

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

42. 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 _____

43. 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 _____

44. 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 _____

45. 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 _____

46. **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 _____

47. **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 _____

48. **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 _____

49. **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 _____

50. **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 _____

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

- ○ Yes
- ○ No

52. **Please list other conditions, surgeries, or problems you feel are significant:**

_____

Vision Rehabilitation Evaluation Questionnaire

53. **Type of injury/accident(s): Please add dates for each injury**

- ☐ Motor vehicle _____
- ☐ Fall _____
- ☐ Blow to head _____
- ☐ Industrial or work-related accident _____
- ☐ Medication-related _____
- ☐ Drug abuse _____
- ☐ Poison or toxic substance _____
- ☐ Carbon monoxide _____
- ☐ Anoxic/lack of oxygen _____
- ☐ Stroke/CVA _____
- ☐ Aneurysm _____
- ☐ Hemorrhage _____
- ☐ Lyme or tick-related _____
- ☐ Other _____

54. **What part of your head was affected? (check all that apply)**

- ☐ Forehead
- ☐ Right side
- ☐ Left side
- ☐ Back of head
- ☐ Top of head
- ☐ Face

55.

	Yes	No
Did you lose consciousness?		
Were you in a coma?		

56. **Symptoms immediately following accident/injury: (check all that apply)**

- ☐ Double vision _____
- ☐ Headache _____
- ☐ Blurred vision _____
- ☐ Pain in or around eyes _____
- ☐ Dizziness _____
- ☐ Vomiting _____
- ☐ Flashes of light _____
- ☐ Disorientation _____
- ☐ Loss of balance _____
- ☐ Neck pain or whiplash _____
- ☐ Loss of memory _____
- ☐ Restricted field of view _____
- ☐ Restricted motion _____
- ☐ Other: _____

57. **Please provide details about your initial treatment:**

When did you first see a doctor regarding your accident/injury?

_____

Name of doctor and their specialty?

Where were you seen?

Were you hosptialized?
☐ Yes ☐ No

If yes, for how long?

What were you or your family told?

What did intial treatments consist of?

What prognosis/recommendations were you given?

Where you given medications?
☐ Yes ☐ No ☐ Unknown

If yes, what medications and for what condition(s)?

58. Subsequent /Other professional care: What types of professional care have you received or are you currently receiving?

Physician name and results/recommendations

Physiatrist or Physical Med and Rehab physician name and results/recommendations

Neurologist name and results/recommendations

Neuropsychologist name and results/recommendations

Physical therapist name and results/recommendations

Occupational therapist name and results/recommendations

Speech/Language therapist name and results/recommendations

Psychologist/Psychiatrist name and results/recommendations

Osteopathic Physician name and results/recommendations

Chiropractor name and results/recommendations

Other

59. Have you been exposed to Lyme or have history of a tick bite? If yes, explain below.

☐ Yes ☐ No ☐ Unknown

_____ _____ _____

60. Has a neurological evaluation been performed? If yes, note with whom and results

☐ Yes ☐ No ☐ Unknown

_____ _____ _____

61. Has a psychological evaluation been performed? If yes, note with whom and results

☐ Yes ☐ No ☐ Unknown

_____ _____ _____

62. Has an occupational therapy evaluation been performed? If yes, note with whom and results

☐ Yes ☐ No ☐ Unknown

_____ _____ _____

63. Has a physical therapy evaluation been performed? If yes, note with whom and results

☐ Yes ☐ No ☐ Unknown

_____ _____ _____

64. Has a vestibular evaluation been performed? If yes, note with whom and results

☐ Yes ☐ No ☐ Unknown

_____ _____ _____

65. Has a speech and language evaluation been performed? If yes, note with whom and results

☐ Yes ☐ No ☐ Unknown

_____ _____ _____

66. Has brain imaging been performed?

☐ Yes ☐ No ☐ Unknown

_____ _____ _____

67. What type of brain imaging has been performed?

☐ MRI ☐ CT ☐ MRA

_____ _____ _____

☐ Other ☐ Unknown

_____ _____

68. What provider ordered the imaging and what was the result?

Visual history

69. Have you had a previous vision evaluation?

☐ Yes ☐ No ☐ Unknown

If yes, date of last eye exam:

If yes, name and location of last eye doctor:

If yes, what were the recommendations?

70. Current contact lens brand (if applicable):

Do you wear glasses?

○ Yes ○ No

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

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

72. Do you currently experience any of the following:

	Yes	No	Had prior to injury
Eye ache			
Bumping into objects or doorways			
Difficulty with sleeping			
Movement in peripheral vision			
Eyes pull or "tug"			
Difficulty moving or turning eyes			
Pain in or around eyes			
Pain with movement of eyes			
Eyes twitch			

73. Do you currently experience any of the following:

	Yes	No	Had before injury
Motion sickness or car sickness			
Difficulty changing focus far to near			
One eye turns in, out, up or down			
Movement of objects in the environment is bothersome			
Difficulty with peripheral vision			
Fluorescent light is bothersome			
Patterned wallpaper or carpets are bothersome			
Head moves when reading			
Words jump or move around when reading			
Short attention span for reading or writing			
Skip words frequently when reading			
Discomfort when reading			
Loss of interest/concentration when doing close work			
Orient writing/drawing poorly on page			
Squinting, covering or closing one eye			
Head tilts during desk work			
Holds books too close			
Avoids reading or writing			
Objects jump in and out of field of vision			

74. Do you currently experience any of the following:

	Yes	No	Had before injury
Reduced depth perception			
Tunnel vision/loss of visual field			
Difficulty with dressing			
Difficulty with bathing/personal hygiene			
Difficulty following a series of directions			
Difficulty using both sides of the body together			
Dislike heights			
Awkward, poor balance			

75. Do you currently experience any of the following:

	Yes	No	Had before injury
Confusion/disorientation			
Gets lost often			
Bothered by noises			
Bothered by touch			
Difficulty remembering things heard			
Difficulty remembering things seen			
Difficulty remembering name of objects			
Difficulty remembering people's names			
Difficulty recalling info known in the past			
Difficulty remembering formerly familiar people/objects			
Difficulty performing tasks formerly easy/routine			
Difficulty with time management			
Difficulty with numbers			
Difficulty counting money			

76. Why do you feel the need for a vision evaluation?

Lifestyle

77. Do you feel like your vision interferes with activities of daily living (home, work, hobbies, social and personal relationships)?
☐ Yes ☐ No

If yes, please explain how vision interferes with activities of daily living.

_____

78. **What activities comprise the majority of your daily life since your accident/injury?**

_____
_____
_____
_____

79. **What activities can you no longer engage in due to your visual or other difficulties?**

_____
_____
_____
_____

80. **What other changes/limitations in your daily life do you attribute to your accident/injury?**

_____
_____
_____
_____

81. **What do you hope a visual rehabilitation program can do for you?**

_____
_____
_____
_____

Employment/Education Information (If applicable)

82. What was your employment or student status PRIOR to the accident or injury?
☐ Full-time ☐ Part-time ☐ Retired ☐ Other

What was your employment or student status AFTER the accident or injury?
☐ Full-time ☐ Part-time ☐ Retired ☐ Other

What is your occupation or if a student, what is the major course of study or grade?

_____

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

83. **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

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

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