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. **Insurance Cards**

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

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

- ○ No
- ○ Workers compensation
- ○ Auto accident

15. 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 _______________

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

____

____

____

____

17. **Preferred pharmacy and location**

____

____

____

____

Reason For Visit

18. **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

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

	Yes	No
Blurred vision at distance		
Blurred vision at near		
Eye dryness		
Eye strain		
Double vision at distance		
Double vision at near		
Dizziness		
Light sensitivity indoors		
Light sensitivity outdoors		
Loss of Place when reading:		

20.

	Yes	No
Any concerns with development or school?		
Do you wear sunglasses when outside?		

21. 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?

---

22. **Are you currently receiving any therapies?**

- ☐ No ____________
- ☐ Vision Therapy ____________
- ☐ Occupational therapy ____________
- ☐ Physical therapy ____________
- ☐ Speech therapy ____________
- ☐ Chiropractor ____________
- ☐ Other ____________

Please list location and/or name of therapists

____

Personal Eye Health History

23. **Are you having any of the following eye concerns?**

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

24. **Do you having any of the following vision concerns?**

	Yes	No
Eye pain		
Poor night vision		
Total loss of vision		
Flashes		
Floaters		
Watery eyes		
Light sensitivity		
Dizziness		

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

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

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.			

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

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

- Yes
- No
- Unknown

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

- Yes
- No
- Unknown

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

- ○ 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 (optional):**

____

Quality of Life Symptom Survey

53. **Check the column which best represents the occurrence of each symptom**

	Never	Seldomly	Occasionally	Frequently	Always
Blue when looking at near					
Double Vision					
Headaches with near work					
Words run together when reading					
Burning, itchy, watery eyes					
Falls asleep reading					
Sees worse at the end of the day					
Skips / repeats lines when reading					
Dizziness / nausea with near work					
Head tilt / closing one eye when reading					
Difficulty copying from chalkboard					

Avoids near work / reading					
Omits small words when reading					
Writes uphill / downhill					
Misaligns digits / columns of numbers					
Reading comprehension down					
Poor / inconsistent in sports					
Holds reading too close					
Trouble keeping attention on reading					
Difficulty completing assignments on time					
Always says "I can't" before trying					
Avoids sports / games					
Poor hand / eye coordination (poor handwriting)					
Does not judge distance accurately					
Clumsy / knocks things over					
Does not use his / her time well					
Does not make change well					
Loses belongings / things					
Car / motion sickness					
Forgetful / poor memory					

Add any additional details here

Employment/Education Information (If applicable)

54. 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

55. 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

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

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

___

___

___

___