ADVANCED EYECARE OPTOMETRY ROBERT TURCIOS, JR., O.D.

WELCOME TO OUR OFFICE

Name _____

Street _____

City _____ State Zip _____

Home Phone _____ Work Phone _____

E-mail address _____

Social security number _____

Employer _____

Today's date _____ Date of last exam _____

Date of birth _____ Age _____ Sex _____

Spouse (or parent name) _____

Spouse (or parent) work phone _____

Childrens' names _____

_____

Medical insurance _____

Do you participate in flexible spending account? _____

Occupation _____

Hobbies

Personal & Family medical history

		Who?			Who?
Allergies	No Yes	_____	Glaucoma	No Yes	_____
Asthma	No Yes	_____	Eye Disease	No Yes	_____
Arthritis	No Yes	_____	Heart Disease	No Yes	_____
Cancer	No Yes	_____	Eye Injury	No Yes	_____
Eye Surgery	No Yes	_____	High blood Pressure	No Yes	_____
Diabetes	No Yes	_____	Use alcohol	No Yes	_____
Smoke	No Yes	_____			

Current Medications (Rx & Over-the-Counter)

Antihistamines	No Yes	_____	_____
Diuretics (water pills)	No Yes	_____	
Blood pressure pills	No Yes	_____	
Oral contraceptives	No Yes	_____	
Sleeping tablets	No Yes	_____	
Eye drops	No Yes	_____	
Other_____	No Yes		

Are you currently under the care of a physician? _____

If yes, physician's name _____

How did you hear about our office?

□ Friend or relative. Who? _____

□ Another health care practitioner. Who? _____

□ Yellow pages. Which directory? _____

□ Newspaper advertisement. Which paper? _____

□ Radio advertisement. Which station? _____

□ Previous patient. Who? _____

□ Participating eye care plan

□ Other

I agree to pay when services are rendered. I understand that any unpaid balance 30 days or more past due is subject to a rebilling fee of $4.00 per month. (Other arrangements must be made in advance).

Signature _____

Main reason for today's visit _____

Diagnostic Issues

Please list any complaints about wearing glasses or contacts?

_____

_____

* Do you have more than 1 pair of current Rx glasses?	NO YES
*Do you work on a computer for long periods?	NO YES
* If you wear glasses, would you benefit from thinner, lighter lenses?	NO YES
* If you wear bifocals, are you bothered by restricted windows, lines or head tilting?	NO YES
* If you wear contact lenses, are you satisfied with vision and comfort?	NO YES
* Are you interested in a "test drive" of the latest in contact lens design?	NO YES
* Laser vision correction is a common choice to reduce or eliminate the need for glasses or contacts Do you desire information regarding laser vision correction and /or a free evaluation regarding your candidacy?	NO YES
* Do you spend a lot of time outdoors?	NO YES

Do You Experience...

Any discomfort with your eyes?	NO YES
Problems with glare or reflection?	NO YES
Sensitivity to light?	NO YES
Headaches?	NO YES
Floaters or flashes of light?	NO YES

How will you settle your account today?

□ Check □ Cash □ Credit card □ Payment plan