Dr. Chad W. Lawson
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Portland, OR 97229

☐ **NEW PATIENT** ☐ **RETURN PATIENT** **(All information will be Confidential)**

Patient Name_____ Today's Date _____ Date of Birth _____

E-mail address_____

Address _____ City/State/Zip _____

Phone: Home_____ Work _____ Cell_____

Marital Status _____

What is your preferred method of communication ? Phone Email Mail

Reason for today's visit ☐ Reminder Card/Postcard ☐ Glasses ☐ Contacts Injury/Medical Exam☐

Other_____

(NEW Patients) Whom may we thank for referring you to our office?

☐ Other healthcare professional _____ ☐ Family Member Insurance listing

☐ Friend _____ Office sign/drive by Office Web site ☐ ☐

☐ ☐ ☐ ☐

Insurance Information

S. S. # _____

Vision Insurance Co. _____ ID/Policy_____

Relationship to Insured? _____ Group# _____

Employer Name _____

DO YOU HAVE ADDITIONAL INSURANCE WE SHOULD BILL? ☐ YES NO

Visual Information

Date of last vision exam _____

Please circle all that you are experiencing with your current correction:

☐ Blur far away	☐ Eyes itch	☐ Discharge from eyes
☐ Blur up close	☐ Eyes water easily	☐ Light sensitivity
☐ Headaches	☐ Dry eyes	☐ Eyes burn
☐ Squinting	☐ Sleepy w/reading	☐ Eye strain/tired eyes
☐ Night vision problems	Pain in or around eyes	Floaters or spots
☐ Double vision	☐	
☐ ☐		

Have you had any eye injury, infection or surgery?

☐ YES NO Explain _____

Health Information

Please list any medications you are taking and their purpose:

_____

_____

Have you had any significant changes in your health or any major health problems? ☐ YES NO

Explain _____

Do you or does anyone in your family have a history of:

		Self	Family		Self	Family		Self	Family
☐	High Blood Pressure	☐	☐	Arthritis	☐	☐☐	Amblyopic (lazy eye)	☐	☐
☐	Heart Disease	☐	☐☐	Epilepsy	☐	☐	Eye Disease	☐	☐
☐	Stroke	☐	☐	Cancer	☐	☐	Cataract	☐	☐
☐	Diabetes	☐	☐	Hypoglycemia	☐	☐☐	Allergies/Hay Fever	☐	☐
☐	Thyroid Problems	☐	☐	Glaucoma	☐	☐☐	Strabismus (crossed eyes)	☐	☐
	Macular Degeneration	☐	☐						

Do you use any of the following on a regular basis: ____Tobacco _____Alcohol _____Other Substances

Are you allergic to any medications? ☐ YES NO Please list _____

LIFESTYLE FACTORS

Your answers will assist us in selecting the best eyewear for you!

Your current Occupation _____

Do you participate in hobbies or outdoor activities?_____

Do you use a computer? YES NO

Do you drive long distances? YES NO ☐

Do you like to watch TV? YES NO

CONTACT LENSES WEARERS

If you currently wear contacts, what brand and type are they? Soft Gas Perm Brand _____

Please initial that you have read and understand the contact lens fitting fees listed in our Contact Lens Information Sheet provided on this clipboard. **_____(int)**

FRAME POLICY

Please initial that you have read and understand the Frame Policy information Sheet provided on this clipboard.
_____(int)

PAYMENT POLICY

Please initial that you have read and understand the Cornell Eyecare Payment Policy provided on this clipboard.
_____(int)

Optomap Retinal Exam: The ultra wide field imaging technology of the Optomap provides an in-depth view of the retinal layers where diseases start. By combining our doctor's expertise and the Optomap wide view images, you and Dr. Lawson can make informed decisions about your eye health and overall wellness.

PLEASE NOTE: Insurance typically does not cover any advance screening technology beyond the general exam. Dr. Lawson strongly believes that the Optomap is an essential part of your comprehensive eye exam and highly recommends it for all the patients annually. The non covered fee is $29

Authorization - I certify that I have read, understand and answered the above information to the best of my knowledge. I consent for Cornell Eyecare to bill my insurance company.

X _____

Signature of Patient (Or parent if a minor) Date Doctor Initials/Date