Dr. Chad W. Lawson

☐ **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___________________________

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

Demandforce/E-mail 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 ˜ Demandforce

˜

˜ ˜ ˜ ˜

Insurance Information:

S. S. # ______________________________________

<u>Vision</u> 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 ____

____

Please turn the page over to complete the backside. Thank you.

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. _________**(initial)**

FRAME POLICY

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

_________**(initial)**

PAYMENT POLICY

Please initial that you have read and understand the Golden Optical Payment Policy provided on this clipboard.

_________**(initial)**

Optos Retinal Photo: The **opto**map is the only technology that provides an ultra-wide field view of the retina. By combining our doctor's expertise and the **opto**map wide-view images, you and our doctors can make informed decisions about your eye health and overall wellness.

PLEASE NOTE: The Optomap Retinal Screening is considered a "non-covered service" with your health plan, meaning that you would be responsible for the charges. Dr. Lawson and Dr. Schmitt strongly believe the Optomap Retinal Screening is an essential part of your comprehensive eye exam and highly recommend it for all patients once per year. Our fee for the Optomap Retinal Exam is $30.

_________ **(initial)**

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

X ____

Signature Date