Welcome to Montclair Vision Services!

Today's Date: ___/____/____ **Whom may we thank for referring you:** ______________________________

Patient's Name: ____________________________ **Date of Birth:** ____/_____/____ **Age:** ________

Mailing Address: ____

(Street) (Apt/ Fl.) (City) (State) (Zip Code)

Home Ph#: _____________________ **Work Ph#:** _____________________ **Cell Ph#** _________________

Occupation: ________________ **Employer:** _________________ **E-mail:** _____________________________

If a student: Grade: _________ **School Name:** __________________ **Parent's Name:** ___________________

INSURANCE INFORMATION:

Do you have a vision plan: ___**Yes or** ___**No? Name of Vision Insurance:** _____________________________

Name of Medical Insurance: ________________________________ **ID Number:** _______________________

Name of Primary Insured: _________________**DOB:** __/__/____ **Last 4-digits of Social Security #:** ____________

WILL TODAY'S EXAMINATION BE PAID FOR BY: **(Circle One)**

CASH **CHECK** **MASTERCARD** **VISA** **DISCOVER** **MEDICARE/MEDICAID**

Family Health History (Check if someone in your family has had)

_____ Allergies
_____ Asthma
_____ Cancer
_____ Diabetes
_____ Glaucoma
_____ Drug sensitivity
_____ Blindness
_____ Hay Fever
_____ Skin condition
_____ High blood pressure
_____ Tuberculosis
_____ Thyroid condition
_____ Cataracts
_____ Poor color vision
_____ Dry Eyes
_____ Lazy eye
_____ Turned eye
_____ Migraine headaches

Patient's Health History (Check if you have had)

______ Allergies
______ Asthma
______ Blackouts
______ Cancer
______ High blood pressure
______ Diabetes
______ Migraine headaches
______ Hay fever
______ Heart condition
______ Skin conditions
______ Thyroid condition
______ Tuberculosis

Patient's Visual History (Check if you have had)

_____None, periodic eye examination
_____ Distance vision blurred
_____ Near-vision blurred
_____ Discomfort at near visual tasks (reading, sewing)
_____ Discomfort at distance visual tasks (driving, movies)
_____ Eyelids twitching
_____ Light sensitivity
_____ Double vision
_____ Lazy eye
_____ Variable vision
_____ Glaucoma
_____ Eye strain
_____ Temporary loss of vision
_____ Watering eyes
_____ Itching eyes
_____ See flashing light
_____ See floaters or spots
_____ Headaches related to eye
_____ Burning eyes
_____ Red eyes
_____ Poor color vision
_____ Dry Eyes
_____ Turned eye

PLEASE COMPLETE BOTH SIDES

Family Physician: ________________________________ Last general physical exam date: ___/__/____
Previous eye doctor's name: _______________________ Last eye examination date: __/__/____

Are you being treated for any medical conditions now? ________Yes _______No
If so, what: ____
Are you pregnant? ____________ Yes ________ No
Do you consider your health? ________ Good ___________ Fair ______________ Poor
Do you take medications? __________ Yes __________ No
If so, list here: ____
Are you allergic to any medications? _______ Yes ___________ No
If so, list here: ____

Do you smoke? _________ Yes ___________No
Do you drink alcoholic beverages? ___________ Yes _________ No
Have you ever had a serious eye disease, eye injury? _______ Yes ___________ No
If so, explain: ____
____

Do you wear eyeglasses? ___________ Yes or _________ No
Do you wear contact lenses? ___________ Yes or _________ No
If yes, which type? ____________ Hard or __________ Soft

DO I NEED TO HAVE MY EYES DILATED?

On the patient's visit, a comprehensive eye exam many times will include pupillary dilation, which is also included in the price of the eye exam. This is used not only to determine the health of the eyes but the health of the patient. Pupillary dilation allows viewing of the internal eye in great detail and permits the doctor to discover early detection of potentially serious eye health problems such as glaucoma, cataracts, and vascular disease. The procedure can also reveal any potentially damaging diseases such as diabetes, hypertension, drug toxicity, tumors and neurological disease. The eye drops will dilate the pupils and will cause some sensitivity to light and some mild blurring of vision; these symptoms typically last 3 to 4 hours and will cause trouble reading (distance vision/driving should be unaffected). You will be given a tinted shield to wear when you leave to help you cope with the light. It is extremely important to inform us of your medical history and ocular symptoms.

Should the patient be unable to undergo dilation on the day of their examination, they will have to schedule an appointment for another day/time. If the patient wishes to forgo dilation altogether, they must sign a waiver.

Please Circle One:
I have read the above and **wish** or **do not wish** to have my eyes dilated

Patient signature: ___________________________________