Guardian: _____

Name: _____

Address: _____

City, St: _____ **Zip:** _____

Phone(H): _____ W: _____ C: _____

Date of Birth: _____ **Sex:** _____

E-Mail: _____

Occupation: _____

Notify me by: ☐ Phone ☐ Email ☐ Mail

Who may we thank for referring you to our office?

☐ Friend ☐ Insurance ☐ Phone Book ☐ Other...

Emergency Contact Name and Phone:

Approx. Date of Last Eye Exam:

What is the major purpose of this visit:

- ☐ Blur at Far
- ☐ Blur at Near
- ☐ Blur at Far & Near
- ☐ Red eye
- ☐ Itching
- ☐ Burning
- ☐ Redness
- ☐ Eye pain
- ☐ Eye strain
- ☐ Flashes/Floaters
- ☐ Loss of vision
- ☐ Loss of side vision
- ☐ Double vision
- ☐ Sandy/Gritty Feeling
- ☐ Foreign Body Sensation
- ☐ Spots or shadows
- ☐ Diabetes eye check
- ☐ Medical eye check
- ☐ Other...

Which Eye? ☐ Right eye ☐ Left eye ☐ Both eyes

How long has it bothered you?

- ☐ Started today
- ☐ 1-2 days
- ☐ 3-7 days
- ☐ 1-2 weeks
- ☐ 2-4 weeks
- ☐ 1-3 months
- ☐ 3-6 months
- ☐ Over 6 months

Severity? ☐ Mild ☐ Moderate ☐ Severe

Getting Worse?

☐ Getting better ☐ Getting worse ☐ About the same

Current Prescription:

Glasses: Right

Left

Contacts: Right

Left

Savaglio Family Vision
3916 - 67 St
Kenosha, WI 53142
262-657-7850
www.savagliovision.com

Please note that insurance does NOT cover the Contact Lens Fitting Evaluation

Primary Insurance

Ins. Name: _____

Ins Number: _____

Relationship: _____

Insured: _____

Insured DOB: _____ **Ins. Sex:** ○ M ○ F

Co-pay: _____ **Materials:** ○ Y ○ N

Secondary Insurance

Ins. Name: _____

Ins Number: _____

Relationship: _____

Insured: _____

Insured DOB: _____ **Ins. Sex:** ○ M ○ F

Co-pay: _____ **Materials:** ○ Y ○ N

Do you participate in a flex spending account?

☐ Y ☐ N

How will you settle your account today?

☐ Cash ☐ Check ☐ Credit Card

Medical Doctor(s):

Past Medical History

- ☐ Ambylopia
- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune
- ☐ Cancer
- ☐ Cataract
- ☐ Crossed eyes
- ☐ Diabetes
- ☐ Droopy lid
- ☐ Ear/Nose
- ☐ Eye infections
- ☐ Eye injuries
- ☐ Eye Surgery
- ☐ Gastrointestinal
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ High B.P.
- ☐ Keratoconus
- ☐ Kidney
- ☐ LASIK
- ☐ Lazy eye
- ☐ Lupus
- ☐ Macular Degen.
- ☐ Migraine
- ☐ MS
- ☐ Neurological
- ☐ Psychological
- ☐ Respiratory
- ☐ Sinus
- ☐ Thyroid
- ☐ Other...

Eye wear History

- ☐ Glasses
- ☐ Bifocals
- ☐ Trifocals
- ☐ No- line
- ☐ Soft Contacts
- ☐ Toric Soft
- ☐ Gas Perm
- ☐ Hard
- ☐ Monovision
- ☐ Disposable
- ☐ Overnight wear

Mark box if yes.

- ☐ Have you tried contact lenses?
- ☐ Not satisfied with the vision comfort of your contact lenses?
- ☐ Would prefer colored contacts?
- ☐ Do the lines and head tilting bother you with bifocals?

Allergies

- ☐ None
- ☐ Penicillin
- ☐ Sulfa
- ☐ Eye drops
- ☐ Novocain
- ☐ Seasonal
- ☐ Codeine
- ☐ Other...

Social History

- ☐ Computer
- ☐ Reading
- ☐ Smoker
- ☐ No Tobacco
- ☐ Student
- ☐ Music
- ☐ Skiing
- ☐ Golf
- ☐ Fishing
- ☐ Tennis
- ☐ Shoot
- ☐ Swim
- ☐ Bike
- ☐ Drug Abuse
- ☐ Alcohol Abuse
- ☐ No alcohol or drug abuse
- ☐ Other...

Current Medicines — Amount

Family History

- ☐ Blindness
- ☐ Cataracts
- ☐ Crossed Eyes
- ☐ Color Blind
- ☐ Diabetes
- ☐ Kidney Disease
- ☐ Macular Degen.
- ☐ Retina Disease
- ☐ Retina Detach
- ☐ Heart Disease
- ☐ High B.P.
- ☐ Thyroid
- ☐ Glaucoma
- ☐ Cancer
- ☐ None
- ☐ Other...

Lifestyle Questions

Do you...(Check box if your answer is yes)

- ☐ work at a computer? How many hours a day?
- ☐ think you might benefit from thinner lenses?
- ☐ like to "test drive" the latest contact lenses?
- ☐ spend time outdoors?
- ☐ prefer not to wear your glasses at times?
- ☐ want info. on Laser Vision Correction surgery?
- ☐ have more than 1 pair of current Rx eyewear?

I certify that if I and/or my dependents have insurance coverage, I assign all benefits directly to Savaglio Family Vision for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. I authorize Savaglio Family Vision to release any information, including diagnosis and the records of any treatment or examination, of me or my dependents, during the period of care to third party payers and/or health practitioners. I acknowledge that I have been offered the Notice of Privacy Practices and have been povided an opportunity to review it. The information provided on this form is accurate to the best of my knowledge.

Signature_____ Date_____

Relationship to Patient: _____

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