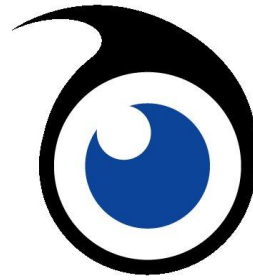


Guardian: \_\_\_\_\_  
 Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City, St: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone(H): \_\_\_\_\_ W: \_\_\_\_\_ C: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_  
 E-Mail: \_\_\_\_\_  
 Occupation: \_\_\_\_\_



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

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:**

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

Which Eye?  Right eye  Left eye  Both eyes

How long has it bothered you?

- |  |                                     |  |
|--|-------------------------------------|--|
| <input type="checkbox"/> Started today | <input type="checkbox"/> 1-2 weeks  | <input type="checkbox"/> 3-6 months    |
| <input type="checkbox"/> 1-2 days      | <input type="checkbox"/> 2-4 weeks  | <input type="checkbox"/> Over 6 months |
| <input type="checkbox"/> 3-7 days      | <input type="checkbox"/> 1-3 months |  |

Severity?  Mild  Moderate  Severe

Getting Worse?

- Getting better  Getting worse  About the same

**Current Prescription:**

Glasses: Right \_\_\_\_\_  
 Left \_\_\_\_\_  
 Contacts: Right \_\_\_\_\_  
 Left \_\_\_\_\_

**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

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

### Eye wear History

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

### 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       Sulfa       Novocain       Codeine
- Penicillin       Eye drops       Seasonal       Other...

### Lifestyle Questions

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

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

### Social History

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

### Current Medicines

### Amount


### Family History

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

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 provided an opportunity to review it. The information provided on this form is accurate to the best of my knowledge.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_