Guardian: _____

Name: _____

Address: _____

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

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

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

E-Mail: _____

Occupation: _____

Notify me by: ☐ Text ☐ Phone ☐ Emai ☐ Mail

Who may we thank for referring you to our office?

☐ Friend ☐ Insuranc ☐ Phone Book ☐ Other...

Emergency Contact Name and Phone:

_____

Approx. Date of Last Eye Exam:

CHRIS R. RAND, O.D.
TX LIC# 6323TG
801 McClintic Dr.
Groesbeck TX, 76642
254-729-4323
Fax- 254-729-4327
www.visionsource-randoptical.com

Race
- ○ American Indian or Alaska
- ○ Asian
- ○ Black or African-
- ○ Native Hawaiian or Other Pacific
- ○ Other
- ○ Unknown/undetermine
- ○ White

Ethnicity
- ○ Not Hispanic or Latino 2186-5
- ○ Hispanic or Latino 2135-2

Language ☐ English ☐ French ☐ Unknown ☐ Spanish ☐ Japanes ☐ Other...

Smoking
- ○ Current every day
- ○ Current some day smoker
- ○ Former smoker
- ○ Heavy tobacco
- ○ Light tobacco smoker
- ○ Never

What is the major purpose of this visit:

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

Which Eye? ☐ Right eye ☐ Left ☐ 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 ☐ Moderat ☐ Sever

Getting Worse?

☐ Getting better ☐ Getting worse ☐ About the same

Current Prescription:

Glasses: Right _____

Left _____

Contacts: Right _____

Left _____

Medical Doctor(s):

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

Vision or Primary Insurance

Ins. Name: _____

Ins Number: _____

Relationship: _____

Insured: _____

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

Co-pay: _____ **Materials:** ○ Y ○ N

Medical or Secondary Insurance

Ins. Name: _____

Ins Number: _____

Relationship: _____

Insured: _____

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

Co-pay: _____ **Materials:** ○ Y ○ N

Participate in a flex spending account? ☐ Y ☐ N

Past Medical History

- ☐ Allergy
- ☐ Amblyopia
- ☐ Asthma
- ☐ Cataract
- ☐ Crossed Eyes
- ☐ Diabetes 1
- ☐ Diabetes 2
- ☐ Droopy Lid
- ☐ Ear
- ☐ Eye Infection
- ☐ Eye Injury
- ☐ Glaucoma
- ☐ Heart disease
- ☐ High B.P.
- ☐ Keratoconus
- ☐ Kidney
- ☐ Lasik
- ☐ Macular Degen.
- ☐ Melanoma
- ☐ Migraine
- ☐ MS
- ☐ Respiratory
- ☐ Sinusitis
- ☐ Stye
- ☐ 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
- ☐ Sulf
- ☐ Eye drops
- ☐ Other...

Social History

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

Current Medicines

Current Medicines	Amount

Family History

- ☐ Blindness
- ☐ Cancer
- ☐ Crossed Eyes
- ☐ Color Blind
- ☐ Diabetes 1
- ☐ Diabetes II
- ☐ Kidney
- ☐ Macular Degen.
- ☐ Retina Detach
- ☐ Heart Disease
- ☐ High B.P.
- ☐ Thyroid
- ☐ Glaucoma
- ☐ None
- ☐ Other...

Lifestyle Questions

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

- ☐ Work at a computer often?
- ☐ Think you might benefit from thinner lenses?
- ☐ Would 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
- ☐ Have more than 1 pair of current Rx

Our office requires payment at the time of service unless we "accept assignment" on your insurance. **You are responsible if your insurance doesn't cover the cost. Contact lens fitting is billed separately from your eye exam.** Your information is protected by our privacy policy**.**

I have received a copy of the clinic "Notice of Privacy Practices".

Remind me of my appointment by: ☐ Text

Signature_____ Date_____

Relationship to Patient: _____