TotalVision
WE KEEP THE CARE IN EYECARE

Welcome to Our Office

DR. LAWRENCE LEFLAND
Optometrist

Date ______________________

Patient's Name: Mr/Mrs/Dr/Miss/Ms. ________________________________ Date of Birth ______________

Street ____ Social Security #______________

City/State ____ Zip Code ______________

Home Phone ______________ Cell Phone ______________ Work Phone ______________

If Child, Parents' Names: ______________ Parents' Occupations ______________________

Spouse's Name ______________________ Spouse's Occupation ______________________

Children's Names & Ages ____

Family members examined in this office ______________ Date of last eye exam and Dr.'s name ______________

Primary Care Physician's Full Name ________________________________ Phone ______________

Street ______________________ City ______________________ Zip Code ______________

Medical/Vision Insurance

Primary Insurance ______________________ Secondary Insurance ______________________

Patient's ID # ______________________ Patient's ID # ______________________

Primary Insured's name, d.o.b. & SS # if not patient: d.o.b. _____ Primary Insured's name, d.o.b. & SS # if not patient: d.o.b. __________

Name ______________ SS # ______________ Name ______________ SS # ______________

Does your insurance cover routine eye exams? ○Yes ○No Do you participate in a flexible spending account? ○Yes ○No

Do you need a referral from your primary care physician for medical visits? ○Yes ○No

Medical History—Review of Systems—Detailed

Do you have or have you ever had problems related to:

Constitutional Symptoms

Fever ○Yes ○No
Fatigue ○Yes ○No
Other ______________

Ears, Nose, Throat, Mouth

Hearing Loss ○Yes ○No
Sinus Disorders ○Yes ○No
Other ______________

Cardiovascular

Atrial Fibrillation ○Yes ○No
Heart Disease ○Yes ○No
High Blood Pressure ○Yes ○No
Stroke/TA ○Yes ○No
Other ______________

Respiratory

Asthma ○Yes ○No
Emphysema/COPD ○Yes ○No
Other ______________

Gastrointestinal

Intestinal Conditions ○Yes ○No
Other ______________

Urinary

Flomax Use ○Yes ○No
Kidney Disease ○Yes ○No
Urinary Conditions ○Yes ○No
Other ______________

Musculoskeletal

Arthritis ○Yes ○No
Muscle/Joint/Back Pain ○Yes ○No
Other ______________

Skin

Herpes ○Yes ○No
Rash/Itching ○Yes ○No
Rosacea ○Yes ○No
Shingles ○Yes ○No
Skin Cancer ○Yes ○No
Other ______________

Neurological

Multiple Sclerosis ○Yes ○No
Frequent Headaches ○Yes ○No
Convulsions/Seizure ○Yes ○No
Other ______________

Psychiatric

Memory Loss ○Yes ○No
Depression ○Yes ○No
Other ______________

Endocrine

Diabetes ○Yes ○No
Thyroid Disease ○Yes ○No
Other ______________

Blood

Anemia ○Yes ○No
Cholesterol ○Yes ○No
Other ______________

Allergic/Immunologic

Seasonal Allergies ○Yes ○No
Lupus ○Yes ○No
Other ______________

Pregnant ○Yes ○No
Nursing ○Yes ○No
Other ______________

Eye/Vision History

Have you ever worn or are you currently wearing glasses?
○Yes ○No Age when first worn ______________________

Have you ever worn or are you currently contact lenses?
○Yes ○No Age when first worn ______________________

What kind? ____

Solutions used ____

Are you interested in:

Wearing contacts? ○Yes ○No

Vision correction by laser surgery? ○Yes ○No

How many days do you work on a computer? ______________________

How much time do you spend outdoors? ___________ hrs./week_______

Any problems with your present contact lenses or glasses?

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If you wear eyeglasses, please complete the following:

Do you have more than one pair of current prescription eyeglasses? ○Yes ○No

Are you interested in thinner, lighter lenses? ○Yes ○No

Do you wear bifocals? ○Yes ○No

If so, are you bothered by head tilting, restricted areas of vision correction, etc.? ○Yes ○No

Would you be interested in trying bifocal contact lenses? ○Yes ○No

Are there times when you would rather not wear glasses? ○Yes ○No

Do you have prescription sunglasses? ○Yes ○No

With glasses, are you bothered by glare or reflections, particularly when driving at night? ○Yes ○No

Current Eye Symptoms

Asthenopic

Glare Sensitivity	○Yes	○No
Headaches	○Yes	○No
Light Sensitivity	○Yes	○No
Tired Eyes	○Yes	○No

Physiologic

Burning	○Yes	○No
Drying	○Yes	○No
Tearing	○Yes	○No
Eyelid Swelling	○Yes	○No
Eye Pain or Soreness	○Yes	○No
Foreign Body Sensation	○Yes	○No
Infection of Eye Lid	○Yes	○No
Itching	○Yes	○No
Mucous	○Yes	○No
Ptosis (Drooping Eyelid)	○Yes	○No
Redness	○Yes	○No
Sandy or Gritty Feeling	○Yes	○No

Visual Symptoms

Blurred Vision Distance	○Yes	○No
Blurred Vision Near	○Yes	○No
Distorted Vision	○Yes	○No
Double Vision	○Yes	○No
Flashes of Lights	○Yes	○No
Floaters or Spots	○Yes	○No
Loss of Central Vision	○Yes	○No
Loss of Side Vision	○Yes	○No
Other	○Yes	○No

Additional Notes: ______________________

Past Surgeries

None ☐

Date	Surgery	Surgeon

Allergies to Medications

None ☐

Medication	Reaction

Social History - General

Current Occupation: ______________________________ Years: ________ Employer: ______________________

Do you drink alcohol? ○No ○Occasionally ○1 per day ○2-3 per day ○4+ per day

Do you smoke? ○No ○Occasionally ○1/2 pack per day ○1 pack per day ○1+ pack per day
Past Smoker? ○Yes ○No ○When did you quit smoking? __________________

Do you chew tobacco? ○Yes ○No Do you use nutritional supplements (vitamins etc.)? ○Yes ○No

Do you engage in regular exercise? ○Yes ○No Marital Status: __________________

Ethnicity: ○African American ○Asian ○Caucasian ○Hispanic ○Native American
○Scandinavian ○South Asian

Preferred Language: ○English ○Spanish ○French ○Italian ○Russian ○Portuguese

Height: _________ Feet __________ Inches Weight _________ Pounds

Eye Diseases

Condition	Yes	No
Amblyopia	○Yes	○No
Blepharitis	○Yes	○No
Blindness	○Yes	○No
Cataract(s)	○Yes	○No
Color Blindness	○Yes	○No
Diabetic Retinopathy	○Yes	○No
Dry Eye Syndrome	○Yes	○No
Eye Injuries	○Yes	○No
Glaucoma	○Yes	○No
Glaucoma Suspect	○Yes	○No
High Risk Medications	○Yes	○No
Macular Degeneration	○Yes	○No
Vitreous Detachment	○Yes	○No
Retinal Detachment	○Yes	○No
Strabismus	○Yes	○No

Additional Notes______________________

Family History

Eye Diseases

Condition	Yes	No
Amblyopia (Lazy Eye)	○Yes	○No
Blindness	○Yes	○No
Cataract(s)	○Yes	○No
Color Blindness	○Yes	○No
Eye Tumors	○Yes	○No
Glaucoma	○Yes	○No
Glaucoma Suspect	○Yes	○No
Macular Degeneration	○Yes	○No
Retinal Detachment	○Yes	○No
Strabismus (Eye Turn)	○Yes	○No
Other Eye Conditions	○Yes	○No

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Systemic Diseases

Condition	Yes	No
Arthritis	○Yes	○No
Cancer	○Yes	○No
Diabetes	○Yes	○No
Heart Disease	○Yes	○No
High Blood Pressure	○Yes	○No
Kidney Disease	○Yes	○No
Lupus	○Yes	○No
Stroke	○Yes	○No
Thyroid Disease	○Yes	○No

Additional Notes____________________

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Please list any medications either prescription or over the counter that you may be taking below.

None ☐

Name	Dosage/Frequency

How did you first hear about our office?

- ☐ Referred by another doctor - if so, who?__________________
- ____
- ☐ Referred by a friend - if so, who?______________________
- ☐ Referred by a relative - if so, who?____________________
- ☐ Health Insurance provider Web site
- ☐ Yellow Pages — Which directory?_____________________
- ☐ TotalVision Web site
- ☐ Web Search ○ Google ○ YP.com ○ Yelp
- ☐ Office Sign — Location
- ☐ Other____

We are now making greater use of e-mail to send recall notices and communicate with our patients. To help us provide the most prompt service possible, please enter your current e-mail address below:

NOTE: All patient information Is kept strictly confidential. Your address is NEVER shared.

Patient Obligations Regarding Payments & Insurance Benefits, and HIPAA Acknowledgment

I understand that professional fees are due at the time services are rendered and that a 50% deposit is required before materials can be ordered. Eyewear ordered cannot be cancelled or deposits refunded once lenses and/or frames have been ordered or fabricated by our laboratory. If routine retinal photographs are taken, I am responsible for the additional fee. Unpaid balances will be charged 1-1/2% interest per month or a $2 minimum per month. A $25 fee will be charged for all returned checks. I understand that if due to nonpayment of my balance, it becomes necessary to submit my account to a collection agency and/or attorney, I will be responsible for all fees incurred.

I understand and agree that insurance payments are an arrangement between my insurance carrier and myself. I authorize this office to prepare any insurance forms to assist me in receiving reimbursement from my insurance company. I authorize that payment be made directly to this office and be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me, and that **I am personally responsible for payment, regardless of the actual amount of reimbursement made by my insurance company.** I authorize this office to release any information required to process any insurance claims. My signature below will serve as a “signature on file” for purposes of filing claim forms.

I have been given the opportunity to read and receive a copy of Dr. Lefland’s ***Notice of Privacy Practices***.

How will you settle your account today? **Cash** ☐ **Check** ☐ **Credit Card** ☐

Signature: ____ ______________________________

(Parent or guardian if patient is a minor) **date**