BETHANY OPTICAL
FIND YOUR VISION

□ **NEW PATIENT** □ **RETURN PATIENT** **(All information will be Confidential)**

Patient Name_____ Today's Date _____ Date of Birth _____

E-mail address_____

Address _____ City/State/Zip _____

Phone: Home_____ Work _____ Cell_____

Marital Status _____

What is your preferred method of communication ? Phone Email Mail

Reason for today's visit Routine Eye Exam Glasses Contacts Injury/Medical Other:_____

(NEW Patients) Whom may we thank for referring you to our office?

Other healthcare professional _____ Insurance Sign / Drive by Office Website

Family Member or Friend _____

Insurance Information

Vision Insurance Co. _____

ID/Policy_____ Group# _____

Name of Subscriber: _____ DOB:_____

DO YOU HAVE ADDITIONAL INSURANCE WE SHOULD BILL? YES NO

Visual Information

Date of last vision exam _____

Please circle all that you are experiencing with your current correction:

Blur far away	Eyes itch	Discharge from eyes
Blur up close	Eyes water easily	Light sensitivity
Headaches	Dry eyes	Eyes burn
Squinting	Sleepy w/reading	Eye strain/tired eyes
Night vision problems	Pain in or around eyes	Floaters or spots
Double vision		

Have you had any eye injury, infection or surgery? YES NO

Explain _____

_____

Please turn the page over to complete the backside. Thank you.

Health Information

Please list any medications you are taking and their purpose:

_____

_____

Have you had any significant changes in your health or any major health problems? YES NO If yes, please explain:

_____

Do you or does anyone in your family have a history of:

	Self	Family		Self	Family		Self	Family
High Blood Pressure	☐	☐	Arthritis	☐	☐	Amblyopic (lazy eye)	☐	☐
Heart Disease	☐	☐	Epilepsy	☐	☐	Eye Disease	☐	☐
Stroke	☐	☐	Cancer	☐	☐	Cataract	☐	☐
Diabetes	☐	☐	Hypoglycemia	☐	☐	Allergies/Hay Fever	☐	☐
Thyroid Problems	☐	☐	Glaucoma	☐	☐	Strabismus (crossed eyes)	☐	☐
Macular Degeneration	☐	☐						

Do you use any of the following on a regular basis: ____Tobacco ____Alcohol ____Other Substances

Are you allergic to any medications? YES NO Please list _____

Lifestyle Factors

Your answers will assist us in selecting the best eyewear for you!

Your current Occupation _____

Do you participate in hobbies or outdoor activities?_____

Do you use a computer? YES NO

Do you drive long distances? YES NO

Do you like to watch TV? YES NO

CANCELLATION & NO SHOW POLICY

Please initial that you have read and understand the Bethany Optical Cancellation & No Show Policy provided on this clipboard. **_____(initial)**

CONTACT LENSES WEARERS

If you currently wear contacts, what brand and type are they? Soft Gas Perm Brand _____

Please initial that you have read and understand the contact lens fitting fees listed in our Contact Lens Information Sheet provided on this clipboard. **_____(initial)**

FRAME POLICY

Please initial that you have read and understand the Bethany Optical Frame Policy information sheet provided on this clipboard. **_____(initial)**

PAYMENT POLICY

Please initial that you have read and understand the Bethany Optical Payment Policy provided on this clipboard. **_____(initial)**

Optomap Retinal Exam: The ultra wide field imaging technology of the Optomap provides an in-depth view of the retinal layers where diseases start. By combining our doctor's expertise and the Optomap wide view images, you and Dr. Lawson can make informed decisions about your eye health and overall wellness.

PLEASE NOTE: Insurance typically does not cover any advance screening technology beyond the general exam. Dr. Lawson strongly believes that the Optomap is an essential part of your comprehensive eye exam and highly recommends it for all the patients annually. The non covered fee is $39.

Authorization - I certify that I have read, understand and answered the above information to the best of my knowledge. I consent for Bethany Optical to bill my insurance company.

X _____ _____

Signature of Patient (Or parent if a minor) Date