

Our Mission

We Are Dedicated To Providing Our Patients With The Highest Quality Eye Care And Service Possible. We Will Seek Continuing Education To Remain At The Forefront Of Our Profession And Will Offer The Latest Eye Care Technology And Products. We Are Committed To Delivering This Care With Honesty And Compassion To Better Serve You And Your Family.

Please Complete ALL Sections

| Patient Information | Lifestyle Questions | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|--|---|------------------------------------|---|---|--|---|-------------------------------------|---|----------------------------------|-----------------------------------|-------------------------------------|------------------------------------|----------------------------------|-----------------------------------|--|---|-----------------------------------|---|---|-----------------------------------|--|--|--|--|-----------------------------|
| <p>Today's Date _____</p> <p>Last _____</p> <p>First _____ MI _____</p> <p>Street _____</p> <p>City _____ State _____</p> <p>Zip Code _____</p> <p>Phone Home _____ Cell _____</p> <p>Work Phone _____</p> <p>Patient's SSN _____</p> <p>Date of Birth _____ Age _____</p> <p>Sex M F</p> <p>Email Address _____</p> <p>Employer (or School) _____</p> <p>Driver's License _____ State _____</p> <p>Occupation (or Grade) _____</p> <p>Guarantor (or Parent's Name) _____</p> <p>Guarantor (Employer) _____</p> <p>Guarantor's Address _____</p> <p>City _____ State _____ Zip _____</p> <p>Sex _____ DOB _____ SSN _____</p> <p>What is the purpose of this visit? Are you experiencing any problems with your current contact lenses or eyeglasses? _____</p> <p>_____ <input type="checkbox"/> CC</p> | <p>Do you..... (Check box if your answer is yes)</p> <p><input type="checkbox"/> ..Work at a computer? Hrs. /Day _____ cell phone _____ flat screen tv _____ tablet/I pad _____</p> <p><input type="checkbox"/> ..Think you might benefit from thinner, lighter lenses?</p> <p><input type="checkbox"/> ..Have interest in a "test drive" of the latest contact lens designs</p> <p><input type="checkbox"/> ..Spend time outdoors? How much? _____ Hrs/week</p> <p><input type="checkbox"/> ..Have polarized prescription sun wear?</p> <p><input type="checkbox"/> ..Prefer not to wear your glasses at times?</p> <p><input type="checkbox"/> ..Want information on Laser Vision Correction surgery?</p> <p><input type="checkbox"/> ..Have more than 1 pair of current Rx eyewear?</p> <p><input type="checkbox"/> ..Have children?</p> <p><input type="checkbox"/> ..Have family members in need of eye care?</p> <p><input type="checkbox"/> ..What do you do for fun?</p> <p><u>WHO MAY WE THANK FOR REFERRING YOU?</u></p> <p>___Yellow Pages ___Social media ___Internet / website</p> <p>___Walk in ___Drive by ___Insurance</p> <p>___Family/Friend Name: _____</p> <p>Do you experience or have you been diagnosed or treated for any of the following?</p> <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Blurry Vision</td> <td><input type="checkbox"/> Iritis/Uveitis</td> </tr> <tr> <td><input type="checkbox"/> Cataracts</td> <td><input type="checkbox"/> Corneal Abrasion</td> </tr> <tr> <td><input type="checkbox"/> Crossed eye/Eye turn</td> <td><input type="checkbox"/> Double Vision</td> </tr> <tr> <td><input type="checkbox"/> Eye Infections</td> <td><input type="checkbox"/> Eye Injury</td> </tr> <tr> <td><input type="checkbox"/> Flash of light</td> <td><input type="checkbox"/> Tearing</td> </tr> <tr> <td><input type="checkbox"/> Glaucoma</td> <td><input type="checkbox"/> Grittiness</td> </tr> <tr> <td><input type="checkbox"/> Headaches</td> <td><input type="checkbox"/> Burning</td> </tr> <tr> <td><input type="checkbox"/> Lazy Eye</td> <td><input type="checkbox"/> Itchiness/Allergies</td> </tr> <tr> <td><input type="checkbox"/> Macular Degeneration</td> <td><input type="checkbox"/> Dry Eyes</td> </tr> <tr> <td><input type="checkbox"/> Retinal Detachment</td> <td><input type="checkbox"/> Sunlight Sensitivity</td> </tr> <tr> <td><input type="checkbox"/> Floaters</td> <td><input type="checkbox"/> Trouble seeing at night</td> </tr> <tr> <td><input type="checkbox"/> Uncomfortable glasses</td> <td></td> </tr> <tr> <td><input type="checkbox"/> other eye disorders _____</td> <td><input type="checkbox"/> CC</td> </tr> </table> | <input type="checkbox"/> Blurry Vision | <input type="checkbox"/> Iritis/Uveitis | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Corneal Abrasion | <input type="checkbox"/> Crossed eye/Eye turn | <input type="checkbox"/> Double Vision | <input type="checkbox"/> Eye Infections | <input type="checkbox"/> Eye Injury | <input type="checkbox"/> Flash of light | <input type="checkbox"/> Tearing | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Grittiness | <input type="checkbox"/> Headaches | <input type="checkbox"/> Burning | <input type="checkbox"/> Lazy Eye | <input type="checkbox"/> Itchiness/Allergies | <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Dry Eyes | <input type="checkbox"/> Retinal Detachment | <input type="checkbox"/> Sunlight Sensitivity | <input type="checkbox"/> Floaters | <input type="checkbox"/> Trouble seeing at night | <input type="checkbox"/> Uncomfortable glasses | | <input type="checkbox"/> other eye disorders _____ | <input type="checkbox"/> CC |
| <input type="checkbox"/> Blurry Vision | <input type="checkbox"/> Iritis/Uveitis | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Corneal Abrasion | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Crossed eye/Eye turn | <input type="checkbox"/> Double Vision | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Eye Infections | <input type="checkbox"/> Eye Injury | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Flash of light | <input type="checkbox"/> Tearing | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Grittiness | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Burning | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Lazy Eye | <input type="checkbox"/> Itchiness/Allergies | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Dry Eyes | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Retinal Detachment | <input type="checkbox"/> Sunlight Sensitivity | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Floaters | <input type="checkbox"/> Trouble seeing at night | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Uncomfortable glasses | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> other eye disorders _____ | <input type="checkbox"/> CC | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Insurance Information | Patient Eye History | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <p>Vision Insurance _____</p> <p>Relation to Subscriber _____</p> <p>Subscriber SSN _____</p> <p>Subscriber Birth Date _____</p> <p>Insurance ID _____</p> <p>Policy Group # _____</p> <p>Primary Medical Insurance _____</p> <p>Subscriber Name _____</p> <p>Subscriber SSN _____</p> <p>Subscriber Birth Date _____</p> <p>Insurance ID _____</p> <p>Policy Group # _____</p> <p>How will you settle your account today?</p> <p><input type="checkbox"/> Cash <input type="checkbox"/> Check <input type="checkbox"/> Credit Card</p> | <p>Date of Last Eye Exam: _____</p> <p>By Whom? _____</p> <p><u>Please note that some insurance do NOT cover the Contact Lens Fitting Evaluation.</u></p> <p>Are you interested in contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you currently wear contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What brand of Contacts? _____</p> <p>Solution used? _____</p> <p>Are you satisfied with the vision and comfort of your contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Would you prefer clear contact lenses or colored contact lenses? <input type="checkbox"/> Clear <input type="checkbox"/> Colored</p> <p>If you wear bifocals? Do the lines or head tilting bother you?</p> <p style="text-align: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="text-align: right;"><input type="checkbox"/> CC</p> | | | | | | | | | | | | | | | | | | | | | | | | | | |

The information in this confidential case history form is critical to the evaluation of your vision health exam.

| Patient Medical History | |
|---|---|
| Name of Family Physician _____ <input type="checkbox"/> RFV Town _____ | |
| Date of Last Physical Check-up _____ | |
| CURRENT MEDICATIONS (Rx or Over the Counter) (List name of medications including eye drops, vitamins, & birth control pills) _____ <input type="checkbox"/> PH | |
| Are you allergic to any medications? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, which medications? _____ _____ | |
| Have you had any surgeries? <input type="checkbox"/> Yes <input type="checkbox"/> No Please List _____ | |
| Do you use cigarettes/tobacco, alcohol, or other substances? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> PH | |
| Are you Pregnant? <input type="checkbox"/> No <input type="checkbox"/> Yes Months? _____ | |
| Have you ever been diagnosed or treated for any of following health problems? (Check all that apply to you. Y -yes N- no) | |
| Constitutional _Developmental disability _Weight Loss _Fever _Fatigue _Migraines _Excessive Headaches Skin/Integumentary _Eczema _Skin Cancer _Psoriasis Cardiovascular _Heart Disease _Stroke _Vascular Disease _Hypertension Respiratory _Asthma _Bronchitis _Emphysema Neurological _Multiple Sclerosis _Epilepsy Endocrine _Diabetes _Thyroid Problems Ears/Nose/Throat _Hearing Problems _Upper Respiratory tract infection Other: _____ | Gastrointestinal _Ulcer _Colitis _Digestive Disorder Genitourinary _Urinary Tract infections _Kidney Problems _STD Musculoskeletal _Fibromyalgia _Osteoarthritis _Muscular Dystrophy _Arthritis Psychiatric _Depression _Panic Disorder _Schizophrenia Hematologic/Lymphatic _Anemia _Leukemia _Clotting Disorder Allergic/Immunologic _Drug Allergy _Hay Fever _Lupus _Aids |
| <input type="checkbox"/> PH/ROS | |

| Family Medical/Eye History (Check all that apply) | |
|---|--------------------------------|
| Is there a family medical history of any of the following? <input type="checkbox"/> PH (Please indicate relationship and Mother or Father's side.) | |
| Blindness | <input type="checkbox"/> _____ |
| Cataracts | <input type="checkbox"/> _____ |
| Corneal Problems | <input type="checkbox"/> _____ |
| Diabetes | <input type="checkbox"/> _____ |
| Glaucoma | <input type="checkbox"/> _____ |
| Heart Disease | <input type="checkbox"/> _____ |
| Lazy Eye | <input type="checkbox"/> _____ |
| Macular Degeneration | <input type="checkbox"/> _____ |
| Retinal Problems | <input type="checkbox"/> _____ |

• A contact lens prescription is not the same as a prescription for glasses. Contact lenses are considered Class III Medical Devices by the FDA, which means that they require the highest degree of control due to the potential for complications. Contact lenses cannot be dispensed without additional measurements and evaluation of the lenses on the eyes. The fees for contact lens treatment and medical management are not covered under a routine eye examination. Contact lens exams are highly recommended on an annual basis. The contact lens prescription is good for one year due to valid clinical reasons of maintaining good ocular health and potential prescription changes. Dr Casaus follows the American Optometric Association guidelines for all areas of eye care including contact lenses. It is imperative that you adhere to the wearing schedule and solution regimen prescribed by Dr. Casaus. Once a contact lens prescription is finalized, it is available for a specified number of refills at the Dr's discretion. All associated fees must be paid prior to the dispensing of contact lenses and/or contact lens prescription release. We do not guarantee that every patient who wants to wear contact lenses will be successful with them. If a patient tries contact lenses and decides not to proceed with them, they are not required to purchase contact lenses. The contact lens treatment and medical management fees are non-refundable.

• The treatment recommended by our office is never based on what your insurance company will pay but what your specific needs are. Your treatment should not be governed by your insurance contract. However, it should be understood, that the insurance contract is between the insurance company and the patient, who bears the ultimate financial responsibility. If the insurance company fails to pay **within 60 days** after claim submission, the balance due will be transferred to the patient or guarantor.

Patient portion, including **Contact Lens Fitting** and **Copays**, are due the same day treatment is rendered. Professional fees are nonrefundable. This is an agreement in which you, the patient or legal guardian, agree to pay for professional services and ophthalmic products, rendered by Dr. Deidra M. Casaus and The Vision Store.

It is agreed that if in the event of legal proceeding to collect any part of fees due, the patient or legal guardian agrees to pay additional sum including attorney fees and collection costs.

• *I have read and understand the notice of Privacy disclosed in the HIPPA Form and the information stated above.*

Signature _____ Date _____