COPPERFIELD VISION
WELCOME TO OUR OFFICE

Cell Phone___________________________

GENERAL INFORMATION
Date_______________ Home Phone____________________________ Work Phone___________________________

Mr., Mrs., Ms., Dr.______________________ ________ ____ _____ ___________
(First Name of Patient) (M.I.) (Last Name of Patient) (Nick Name)

Address____ Apt#_________ City/State/Zip__________________________________

Occupation____ Hobbies___________________________ Date of Birth_________________________________

Employed by____ Vision Plan Company____

Social Security # (last 4 digits)_____________________________ Drivers License #_____________________________________

If under 18, Parent or Guardian's Name____ Email Address__________________________________

GENERAL HEALTH HISTORY

	No	Yes		No	Yes		No	Yes
Diabetes	____	____	Cancer	____	____	Learning disability	____	____
High Blood Pressure	____	____	Heart problems	____	____	Thyroid problems	____	____
Arthritis	____	____	Kidney problems	____	____	Are you pregnant?	____	____
Asthma	____	____	High Cholesterol	____	____	Mental Illness	____	____

Medications currently taking____

Known Drug Allergies____

EYE HISTORY
Purpose of today's visit…Glasses____ Contact Lenses____ Bifocal Contact Lenses____ Infection/eye problem____

	No	Yes		No	Yes		No	Yes	Family History
Sinus problems	____	____	Ever see double	____	____	Glaucoma	____	____	_______
Headaches	____	____	Burn, itch, or tear	____	____	Cataract	____	____	
Had eye injury	____	____	Recent eye infection	____	____	Lazy eye	____	____	
Had eye surgery	____	____	Computer use	____	____	Other problems_____________________			
Light flashes	____	____	Using eye drops	____	____	Name of eye drops___________________			

Date of last eye exam____ Last eye doctor____

PUPIL DILATION….You must read and sign this section
Dilation of the pupil is considered standard procedure as part of a comprehensive eye examination. Dilating drops enlarge the size of the pupil (the central black spot of the eye) and allows the doctor a more thorough examination of the retina (the back part of the eye). Dilation assists in the detection of glaucoma, cataracts, diabetic and hypertensive retinal changes, retinal degenerative changes, retinal holes, tears and detachments, and some types of tumors. The side effects are light sensitivity while dilation lasts (4 to 6 hours) and trouble seeing up close (2 to 3 hours). It is possible, however unlikely, that dilation could precipitate a sudden rise in the eye pressure;. If the doctor determines you are at risk, your pupils will not be dilated. You will usually be able to drive home. **We recommend that all patients receive an annual dilated eye exam.**

____ ____
I agree to have my eyes dilated I do not want my eyes dilated

Contact Lenses
Do you have or have you ever had contact lenses No____ Yes____ Last time worn____
Type of contact lenses RGP (hard)____ Soft____ Do you sleep in your contact lenses No____ Yes____ How often do you dispose of your contacts_________________
Would you like new contact lenses today No____ Yes____ For the health and safety of your eyes, we only prescribe daily disposable contact lens.
Cancellation Policy for eyeglasses…Prescription lenses are custom orders. Although the entire process may take up to 2 weeks, the lenses begin being processed immediately. Because of this, there will be a 25% service charge for all cancelled orders for eyeglasses.
If personally referred, whom may we thank for the referral____
If your occupation or recreational activities expose you to risk of flying objects or physical impacts, we recommend polycarbonate lenses for your protection.

Acknowledgement of Receipt…I acknowledge that I was given the opportunity to review Copperfield Vision's Notice of Privacy Practices
Signature____
All insurance must be presented at the time of service. Patients are responsible for all fees. Any uncollected or denied claims from your insurance company are payable by the insured upon demand by this office. We do not bill for service, payment is due at time of service. We gladly accept your check as payment. However, in an effort not to inconvenience you, we reserve the right to electronically debit your account if this item comes back dishonored, plus a $30 (or legal limit) processing fee. Your signature is acceptance of this agreement and its terms. I am an adult 18 years of age or older, or I am the parent/guardian of the minor child whose name appears above and hereby authorize Copperfield Vision to perform such eye care and treatment as it deems necessary or appropriate and consent to such care and treatment.
Signature of responsible Party & Consent to Treat____