WELCOME TO OUR PRACTICE!

We truly appreciate you choosing us to help with your eye health care. Please help us take better care of you by completing the following. All information is strictly confidential.

If you are a new patient - whom may we thank for referring you to us? _____

Please offer any comments you feel would help Dr. Bonds. What are your reasons for today's visit?

_____

_____

_____

PATIENT INFORMATION

Last Name_____ First_____ Initial_____ Birthdate_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Day Phone_____ Employer_____

SS#_____ Marital Status (for insurance purposes) [ ] Married [ ] Single

GUARANTOR OR SPOUSE INFORMATION

(GUARANTOR-PERSON RESPONSIBLE FOR BILLS)

Last Name_____ First_____ Initial_____ Birthdate_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Day Phone_____ Employer_____

Cell Phone#_____ E-Mail Address: _____

SS#_____ Marital Status (for insurance purposes) [ ] Married [ ] Single

MANY DISORDERS ARE INHERITED - PLEASE LIST YOUR HOUSEHOLD FAMILY MEMBERS

NAME	RELATION	AGE	HAS PATIENT SEEN DR. BONDS?	LAST EYE EXAM
_____	_____	_____	YES [ ] NO [ ]	_____
_____	_____	_____	YES [ ] NO [ ]	_____
_____	_____	_____	YES [ ] NO [ ]	_____
_____	_____	_____	YES [ ] NO [ ]	_____

STATE OF OUR FINANCIAL POLICY

Doctor's Fees: Office visit fees are due the day services are performed. Most insurances accepted.
Material's Fees: A 50% deposit is required before ordering. Balance is due before delivery.

WHAT ABOUT YOUR INSURANCE COVERAGES?

We will work hard to help you obtain proper insurance benefits. All deductibles and co-payment amounts are due today. To help our patients financially we are participating providers for: MEDICARE, MEDICAID, CHAMPUS, BC, UNITED, TRICARE, PEEHIP, VSP, GOODYEAR, NEW SOUTHLAND CAL-MED and other insurers.

PLEASE CHECK THE PAYMENT PLAN YOU PREFER

Cash/Check [ ] Credit Card [ ] Insurance [ ]

RESPONSIBLE PARTY _____ DATE _____

I agree to the above terms regarding payment.

Thank you for helping us with your health information!

Dr. Terry L. Bonds

Welcome Back to Our Office

Date_____ Name_____

Changes: In personal information

_____

_____

_____

In medications or health history

_____

_____

_____

Any problems with glasses or contacts?

_____

_____

_____

Diagnostic Issues

Are there any activities you enjoy, but must restrict because of vision?

Yes ☐ No ☐

If yes, please explain:

_____

_____

_____

_____

_____

- Do you have more than 1 pr. of current Rx glasses? No Yes
- Do you work on a computer? No Yes
  If yes, how many hours daily? _____
- If you wear glasses, would you benefit from thinner, lighter lenses? No Yes
- Do you spend a lot of time outdoors? No Yes
- Do you have prescription sunglasses? No Yes
- If you wear bifocals, are you bothered by restricted windows, lines or head tilting? No Yes
- Are there times you'd rather not wear glasses? No Yes
- If you wear contact lenses, are you satisfied with vision and comfort? No Yes
- Are you interested in a risk free "test drive" of the latest in contact lens design(s)? No Yes
- Want info pertaining to laser vision corrections? No Yes
- Have interest in non-surgical approach to vision correction? No Yes

Doctor's Recommendations

____ **Polycarbonate lenses**
Thin, lightweight, impact-resistant

____ **High-index lenses**
Reduce weight and edge thickness in high prescription lenses

____ **Progressive bifocals**
Bifocal lenses with no visible lines

____ **Anti-reflective coating**
Reduces glare for you and for those looking at you

____ **Ultraviolet lens coating**
Protects your vision by blocking ultraviolet light

____ **Polarized lenses**
Enhanced comfort and performance for driving and water-related activities by blocking gate

____ **Photochromic tinted lenses**
Varying degrees of darkening, depending on lens and surrounding lighting

____ **Tinted lenses**
For specific tasks and activities, such as shooting sports or working under fluorescent lights

____ **Daily wear contact lenses**

____ **Extended wear contact lenses**

____ **Colored contact lenses**

____ **Aspheric contact lenses**

____ **Non-prescription sunglasses for contact lens wearer**

____ **Prescription sunglasses**

____ **Computer glasses**

____ **Non-prescription safety glasses**

____ **Prescription safety glasses**

____ **Non-prescription sport glasses**

____ **Prescription sport glasses**

____ **Other** _____

After considering your occupation and lifestyle, Dr. Bonds recommends you consider these enhancements to your spectacles and/or contact lenses. These enhancements are designed to optimally protect your vision based on the way you work and live. For more information on these options, just ask!

for Terry L. Bonds, O.D.

VISION UPDATE

Date of your last eye examination_____

Have you ever worn glasses? ☐ Yes ☐ No Do you wear glasses now? Yes ☐ No ☐

If yes: ☐ for distance only ☐ for near only ☐ wear them full time ☐ for computer monitor ☐ sports

If you wear glasses, do you have:

Prescription sunglasses, in current prescription?	☐ Yes ☐ No
Would you benefit from thinner, lighter lenses?	☐ Yes ☐ No
Do you experience glare or reflection problems?	☐ Yes ☐ No
Do you have current prescription back-up glasses?	☐ Yes ☐ No
Do you wear contact lenses at this time?	☐ Yes ☐ No
Have you had problems wearing contacts?	☐ Yes ☐ No
Have you been told you cannot wear them?	☐ Yes ☐ No
Are you interested in trying contacts risk free?	☐ Yes ☐ No

This is your opportunity to tell us about all areas in which your vision is not serving you well.

What is your main reason for coming here today?_____

_____

Are there times when your vision (or present lens) isn't quite right?_____

_____

Are there any activities you would enjoy doing, but must restrict because of your vision?_____

_____

Are you interested in vision improvement? ☐ Refractive Surgery ☐ Laser Correction ☐ Non-Surgical (CRT)

OCCUPATION: What kind of work do you do? _____

What activities do you do at work (Circle all that apply) driving typing data entry computers program inspecting accounting writing/editing using spread-sheets loading deliveries sales monitor instruments other:_____

Do you use a computer on your job? ☐ **Yes** ☐ **No** # hours daily_____

Do you use a computer at home? ☐ **Yes** ☐ **No** # hours daily_____

What lenses do you wear?	☐ none	☐ glasses	☐ bifocals	☐ contacts
When computing, do your eyes get	☐ red	☐ dry	☐ ache	☐ sore
Do you feel pain or discomfort in your	☐ neck	☐ back	☐ shoulder	
Do letters ever seem to "swim"?	☐ Yes	☐ No		
Does office lighting bother you?	☐ Yes	☐ No		
Do reflections and glare bother you?	☐ Yes	☐ No		
Is it hare to proof-read or find errors?	☐ Yes	☐ No		

Do you experience any of the following discomforts at work or at home?

☐ Headaches? ☐ Letters blur as you read? ☐ Occasionally see double?

☐ Eyestrain? ☐ Eyes red or watery? ☐ Pulling sensation near eyes?

☐ Get sleepy? ☐ Lose your place often? ☐ Do you avoid certain tasks?

☐ Does it take more and more effort to see clearly as the day wears on?

☐ Do you avoid reading after work, but read on weekends? How long can you read?_____

☐ Do you "hunch" closer to your work as the day wears on?

☐ Do street signs ever seem blurred as you drive home from work?

☐ Is it ever difficult to bring print or objects to clear focus? When_____

RECREATION AND LEISURE:

In what recreational activities do you participate: (Circle all that apply) read racquetball tennis hunt fish shoot golf baseball basketball swim camp sew play cards flying video games musical instrument

Other recreational activities: _____

Do you wear any special or protective eyewear for your sport?	☐ Yes ☐ No
Does your vision, or do your lenses, interfere with any activity?	☐ Yes ☐ No
Do you currently wear glasses that have an anti-reflective coating?	☐ Yes ☐ No

Television: is viewing ever uncomfortable? Please describe your discomfort:_____

Do you recline while viewing? ☐ Yes ☐ No Do your lenses work for TV? ☐ Yes ☐ No

Do you often play video games? ☐ Yes ☐ No # of hours daily _____

Medical History

Medical/Eye history (Check all that apply)

	Patient	Family	Relationship
Allergies	☐	☐	_____
Arthritis	☐	☐	_____
Asthma	☐	☐	_____
Blindness	☐	☐	_____
Cancer	☐	☐	_____
Cataracts	☐	☐	_____
Cholesterol	☐	☐	_____
Corneal problems	☐	☐	_____
Diabetes	☐	☐	_____
Eye Infection	☐	☐	_____
Eye Injury	☐	☐	_____
Flashes of light	☐	☐	_____
Floaters/spots	☐	☐	_____
Glaucoma	☐	☐	_____
Heart Disease	☐	☐	_____
High blood pressure	☐	☐	_____
Iritis/ Uveitis	☐	☐	_____
Kidney	☐	☐	_____
Lazy eye	☐	☐	_____
Mucular degeneration	☐	☐	_____
Nerves	☐	☐	_____
Retinal detachment	☐	☐	_____
Thyroid	☐	☐	_____
Other eye disease or surgery	☐	☐	_____

MANY DISORDERS ARE INHERITED-PLEASE LIST YOUR HOUSEHOLD FAMILY MEMBERS

Name _____
Relationship_____ Age_____
Has patient seen Dr. Bonds Yes ☐ No ☐
Last eye exam _____

Name_____
Relationship_____Age_____
Has patient seen Dr. Bonds Yes ☐ No ☐
Last eye exam_____

Name_____
Relationship_____Age_____
Has patient seen Dr. Bonds Yes ☐ No ☐
Last eye exam_____

Name_____
Relationship_____Age_____
Has patient seen Dr. Bonds Yes ☐ No ☐
Last eye exam_____

Current Medications (Rx & Over-the-counter)

			name of medication
Antihistamines	Yes ☐	No ☐	_____
Diuretics (water pills)	Yes ☐	No ☐	_____
Blood pressure pills	Yes ☐	No ☐	_____
Oral contraceptives	Yes ☐	No ☐	_____
Sleeping Tablets	Yes ☐	No ☐	_____
Eye drops	Yes ☐	No ☐	_____
Diabetes Medication/Insulin	Yes ☐	No ☐	_____

Other_____
Allergies to medications?_____
Are you currently under the care of a physician?
Yes ☐ No ☐
Name of physician_____
Last check up_____

[Doctor's use only]

_____
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