

# WELCOME TO OUR OFFICE

Karl B. Czirr, O.D.  
4309 W. 27<sup>th</sup> Place, Suite 102  
Kennewick, WA 99338

Today's Date \_\_\_\_\_

## Patient Information

Last \_\_\_\_\_  
First \_\_\_\_\_ MI \_\_\_\_\_  
Street \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_  
Zip Code \_\_\_\_\_  
Home Phone \_\_\_\_\_  
Work Phone \_\_\_\_\_  
Patient's SSN \_\_\_\_\_  
Insured's SSN \_\_\_\_\_  
Employer (or School) \_\_\_\_\_  
Occupation (or Grade) \_\_\_\_\_  
Spouse (or Parent's Name) \_\_\_\_\_  
Spouse (or Parent's Work) \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
Sex  M  F  
Email Address \_\_\_\_\_

### What is the major purpose of this visit?

\_\_\_\_\_

### Do you want to be fitted for contact lenses today?

Yes  No  Don't know

(There is an additional charge for the fitting of contact lenses because we take the time to ensure good health and a proper fit)

### Do you have any problems with your current contact lenses or eyeglasses?

\_\_\_\_\_

### Who may we thank for referring you to our office?

\_\_\_\_\_

If not referred, how did you choose our office?

- Insurance List  
 Saw Sign/Building  
 Yellow Pages: Which directory? \_\_\_\_\_  
 Newspaper  
 TV  
 Web Page: Which Web Site? \_\_\_\_\_  
 Other

*The mission of CanyonView Family Eye Care is to contribute to a lifetime of healthy vision, providing each patient with the highest quality of vision care and consequent quality of life. We will seek continuing education to remain at the forefront of our profession and will offer the latest eye care technology, professional services, and products. The visual needs and wellness of each patient will always be our first priority. Everything we do will communicate this.*

## Insurance Information

Due to the complexity of billing insurances, we will be unable to bill your insurance if you do not have complete information at the time service is rendered or products are ordered. In addition, we are no longer able to bill insurances that are Secondary to Medicare.

Primary Medical Insurance \_\_\_\_\_

Vision Insurance \_\_\_\_\_

Do you participate in a flex spending account?

Yes No

## Lifestyle/Eyewear Questions

Do you.....(check box if your answer is yes)

- .. work at a computer? How much? \_\_Hrs/week  
 .. have visual difficulty when using a computer?  
 .. have computer glasses to reduce eye strain?  
 .. spend time outdoors? How much? \_\_Hrs/week  
 .. feel satisfied with your sunwear?  
 .. know if your sunwear provides proper protection?  
 .. fish, snow ski or water ski?  
 .. drive for a living or travel extensively by car?  
 .. have problems with glare/reflections, especially at night?  
 .. notice scratches on your current lenses?  
 .. know there are new coatings for plastic lenses which make them nearly as scratch resistant as glass?  
 .. have hobbies where added eye protection is needed?  
 .. have other hobbies requiring special visual needs?  
 .. prefer not to wear your glasses at times?  
 .. want thinner, lighter lenses than you currently use?  
 .. wear progressive/no-line bifocals?  
 .. Are you happy with your current pair?  
 .. want eyeglass lenses that use the latest in technology?  
 .. want a pair of glasses like your current pair?  
 .. have more than 1 pair of current Rx eyewear?  
 .. want information on Laser Vision Correction surgery?

### Have you ever experienced, been diagnosed with or treated for any of the following?

- |   |  |
|---|--|
| <input type="checkbox"/> Blurry Vision            | <input type="checkbox"/> Burning                 |
| <input type="checkbox"/> Cataracts                | <input type="checkbox"/> Corneal Abrasions       |
| <input type="checkbox"/> Crossed eye/Eye turn     | <input type="checkbox"/> Double Vision           |
| <input type="checkbox"/> Eye Infections/Discharge | <input type="checkbox"/> Eye Injury              |
| <input type="checkbox"/> Flash of light           | <input type="checkbox"/> Floaters/Spots          |
| <input type="checkbox"/> Glaucoma                 | <input type="checkbox"/> Grittiness              |
| <input type="checkbox"/> Headaches                | <input type="checkbox"/> Iritis/Uveitis          |
| <input type="checkbox"/> Itchiness                | <input type="checkbox"/> Lazy Eye                |
| <input type="checkbox"/> Macular Degeneration     | <input type="checkbox"/> Occasional dryness      |
| <input type="checkbox"/> Retinal Detachment       | <input type="checkbox"/> Sunlight Sensitivity    |
| <input type="checkbox"/> Tearing                  | <input type="checkbox"/> Trouble seeing at night |
| <input type="checkbox"/> Color Vision Problems    | <input type="checkbox"/> Eye Strain              |
| <input type="checkbox"/> Eye Surgery              | <input type="checkbox"/> Blindness in either eye |
| <input type="checkbox"/> Temporary Loss of Vision | <input type="checkbox"/> Watery Eyes             |

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

### Patient Medical History

Because many general health concerns affect the eyes, we ask you to provide the following information...

Name of Family Physician \_\_\_\_\_

Town \_\_\_\_\_

Date of Last Physical or Check-up \_\_\_\_\_

**CURRENT MEDICATIONS (Rx or Over the Counter)**

(List name of medications including eye drops, vitamins, & birth control pills) \_\_\_\_\_

\_\_\_\_\_

**Allergies to medications?**  Yes  No

If so, what medications? \_\_\_\_\_

\_\_\_\_\_

Have you had any major surgeries?  Yes  No

**Have you ever been diagnosed or treated for the following health problems?**

	Yes	No
Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Blood/Lymph	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Digestive	<input type="checkbox"/>	<input type="checkbox"/>
Ears/Nose/Throat	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine	<input type="checkbox"/>	<input type="checkbox"/>
Eczema/Rashes	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Fevers	<input type="checkbox"/>	<input type="checkbox"/>
Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Integumentary (Skin)	<input type="checkbox"/>	<input type="checkbox"/>
Kidney	<input type="checkbox"/>	<input type="checkbox"/>
Muscle/Bone	<input type="checkbox"/>	<input type="checkbox"/>
Neurological	<input type="checkbox"/>	<input type="checkbox"/>
Psychological	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>
Sinus	<input type="checkbox"/>	<input type="checkbox"/>
Throat Infections	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Unusual weight losses/gains	<input type="checkbox"/>	<input type="checkbox"/>

### Patient Eye History

Date of Last Eye Exam \_\_\_\_\_

By Whom? \_\_\_\_\_

Do you wish for us to request your past records be sent to us from that office?  Yes  No

Would you also like us to request records for any children or your spouse?  Yes  No

Have you ever tried contact lenses?  Yes  No

Do you currently wear contact lenses?  Yes  No

What kind? \_\_\_\_\_

Solutions used \_\_\_\_\_

Are you satisfied with the vision and comfort of your contact lenses?  Yes  No

Do you prefer clear contact lenses or colored contact lenses?  Clear  Colored

### Family Medical/Eye History (Check all that apply)

Is there a family medical history of any of the following:

	Relationship (Mother's or Father's side)
Blindness	<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"/> _____

### Please Read and Sign Below

Please be advised if you are using insurance coverage for today's visit, this is a contract between you and your insurance company...not CanyonView Family Eye Care.

We will inform you if your insurance company has not reimbursed our office in full within 90 days. We will then expect payment from you—your insurance company can then pay you directly. (If by mistake your insurance company sends the payment check to us, we will of course send the money directly to you.)

Signature \_\_\_\_\_

