Gresham Vision Center
125 Nw Miller Ave
Gresham, Or 97030
503-665-3813

# GRESHAM & SANDY VISION CENTERS

Sandy Vision Center
39400 Pioneer Blvd #3
Sandy, Or 97055
503-668-4313

www.greshamvisioncenter.com

## WELCOME TO OUR OFFICE

Name_____ Date of Birth_____ Age____ Gender_____

Mailing Address_____

City_____ State_____ Zip_____ Email address_____

Primary Phone_____ Cell or Home (Please indicate) Employer_____ Phone_____

Secondary Phone_____ Cell or Home (Please indicate) SS#_____ (Required for Billing)

**Vision Insurance**_____ **Medical Insurance**_____

Member Name_____ Member Name_____

Member ID#_____ Required Member ID #_____ Required

Member SS#_____ Member SS#_____

Reason for Today's Visit?_____ Date of Last Exam_____

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

**We are required to include the following information in your Health Record by the Centers for Medicare/Medicaid Services**

Race: White Asian Decline to Answer
Black or African American American Indian
Native Hawaiian/Pacific Islander Other_____
(Please circle one)

Ethnicity: Hispanic or Latino
Not Hispanic or Latino
Decline to Answer
(Please Circle One)

**Please make sure you have read our financial policy and understand that what your insurance quotes us is not a guarantee of payment.**

I have read and understood the information on this form, the form regarding payment agreements and collection policies, release of medical information, assignment of insurance benefits and notice of privacy practices under HIPAA.

Sign_____ Date_____
(Parent or guardian signature if a minor)

Verified By:_____ Date_____ Verified By:_____ Date_____ Verified By:_____ Date_____

PATIENT NAME_____ MEDICAL HISTORY

| | SELF | FAMILY/RELATION | | SELF | FAMILY/RELATION |
|---|---|---|---|---|---|
| Allergies | Y/N | Y/N_____ | Eye Surgery | Y/N | Y/N _____ |
| Arthritis | Y/N | Y/N_____ | Glaucoma | Y/N | Y/N_____ |
| Asthma | Y/N | Y/N_____ | Heart Disease | Y/N | Y/N_____ |
| Cancer | Y/N | Y/N_____ | High BP | Y/N | Y/N_____ |
| Diabetes | Y/N | Y/N_____ | Mac. Degeneration | Y/N | Y/N_____ |
| High Cholesterol | Y/N | Y/N_____ | Thyroid | Y/N | Y/N_____ |
| Eye Injury | Y/N | Y/N_____ | Other_____ | | |

Any significant health changes in the last year?_____

_____

Are you allergic to any medications?(Please list)_____

**LIST ALL CURRENT MEDICATIONS AND DATE STARTED TAKING**

_____

_____

_____

_____

Name of primary care physician/clinic_____Phone_____

Address_____

| | | | | | |
|---|---|---|---|---|---|
| Are you planning on replacing your glasses today? | Yes | No | Any discomfort with your eyes? | Yes | No |
| Do you have more than one pair of current Rx glasses | Yes | No | Problems with glare,reflection, night driving? | Yes | No |
| Do you work on a computer for long periods? | Yes | No | Sensitivity to light? | Yes | No |
| Do you spend a lot of time outdoors? | Yes | No | Headaches? | Yes | No |
| If you wear contact lenses, are you satisfied with vision and comfort? | Yes | No | Floaters or flashes of light? | Yes | No |
| Are you interested in laser vision correction? | Yes | No | | | |
| Do you smoke/vape? | Yes | No | If yes: How many packs_____How many years_____ | | |
| Previous smoker? | Yes | No | If yes: How many packs_____How many years_____ | | |
| When did you quit?_____ _____ | | | Do you use recreational drugs? | Yes | No |

If so please list_____