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

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_____ Make my prescription available via email Y or N (please circle)

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. I confirm that I am receiving a paper copy of my eyeglass prescription today.

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_____