Guardian: _____

Name: _____

Address: _____

City, St: _____ **Zip:** _____

Phone(H): _____ W: _____ C: _____

Date of Birth: _____ **Sex:** _____

E-Mail: _____

Occupation: _____

Notify me by: ☐ Text ☐ Phone ☐ Email ☐ Mail

Who may we thank for referring you to our office?

☐ Friend ☐ Insurance ☐ Phone Book ☐ Other...

Emergency Contact Name and Phone:

_____

Approx. Date of Last Eye Exam:

Wardell Vision Center
1005 24th St. W. Ste. 8
Billings, MT 59102
406-281-8480

Race
- ○ American Indian or Alaska
- ○ Asian
- ○ Black or African-
- ○ Native Hawaiian or Other Pacific
- ○ Other
- ○ Unknown/undetermine
- ○ White

Ethnicity ○ Hispanic or Latino ○ Unknown ○ Not Hispanic or Latino

Language ☐ English ☐ French ☐ Russian ☐ Spanish ☐ Japanes ☐ Other...

Smoking
- ☐ 1 Current everyday
- ☐ 2 Current some day smoker
- ☐ 3 Former smoker
- ☐ 4 Never smoker
- ☐ 5 Smoker, current status unknown
- ☐ 9 Unknown if ever smoked

What is the major purpose of this visit:

- ☐ Blur at Far
- ☐ Blur at Near
- ☐ Blur at Far & Near
- ☐ Itching
- ☐ Burning
- ☐ Redness
- ☐ Eye pain
- ☐ Eye strain
- ☐ Flashes/Floaters
- ☐ Loss of vision
- ☐ Double vision
- ☐ Sandy/Gritty
- ☐ Spots or shadows
- ☐ Diabetes eye
- ☐ Medical eye
- ☐ Other...

Which Eye? ☐ Right eye ☐ Left ☐ Both eyes

How long has it bothered you?

- ☐ Started today ☐ 1-2 weeks ☐ 3-6 months
- ☐ 1-2 days ☐ 2-4 weeks ☐ Over 6 months
- ☐ 3-7 days ☐ 1-3 months

Severity? ☐ Mild ☐ Moderate ☐ Severe

Getting Worse?

☐ Getting better ☐ Getting worse ☐ About the same

Current Prescription:

Glasses: Right _____

Left _____

Contacts: Right _____

Left _____

Medical Doctor(s):

Please note that insurance does NOT cover the Contact Lens Fitting Evaluation

Vision or Primary Insurance

Ins. Name: _____

Ins Number: _____

Relationship: _____

Insured: _____

Insured DOB: _____ **Ins. Sex:** ○ M ○ F

Co-pay: _____ **Materials:** ○ Y ○ N

Medical or Secondary Insurance

Ins. Name: _____

Ins Number: _____

Relationship: _____

Insured: _____

Insured DOB: _____ **Ins. Sex:** ○ M ○ F

Co-pay: _____ **Materials:** ○ Y ○ N

Participate in a flex spending account? ☐ Y ☐ N

Past Medical History

- ☐ Allergy
- ☐ Amblyopia
- ☐ Asthma
- ☐ Cancer
- ☐ Cataract
- ☐ Crossed Eyes
- ☐ Diabetes I
- ☐ Diabetes II
- ☐ Droopy Lid
- ☐ Ear Problem
- ☐ Eye Infection
- ☐ Eye Injury
- ☐ Eye Surgery
- ☐ Gastrointestinal
- ☐ Glaucoma
- ☐ Heart
- ☐ High B.P.
- ☐ Keratoconus
- ☐ Kidney
- ☐ Lasik
- ☐ Lazy Eye
- ☐ Macular Degen.
- ☐ Migraine
- ☐ MS
- ☐ Psychological
- ☐ Sinus
- ☐ Thyroid
- ☐ Other...

Eye wear History

- ☐ Glasses
- ☐ Bifocal
- ☐ Trifocal
- ☐ No- line
- ☐ Soft Contacts
- ☐ Toric Soft
- ☐ Gas Perm
- ☐ Hard
- ☐ Monovision
- ☐ Disposable
- ☐ Overnight

Mark box if yes.

- ☐ Have you tried contact lenses?
- ☐ Not satisfied with the vision comfort of your contact lenses?
- ☐ Would prefer colored contacts?
- ☐ Do the lines and head tilting bother you with bifocals?

Allergies

- ☐ None
- ☐ Penicillin
- ☐ Sulfa
- ☐ Eye drops
- ☐ Other...

Social History

- ☐ Computer
- ☐ Reading
- ☐ Student
- ☐ Music
- ☐ Skiing
- ☐ Golf
- ☐ Fishing
- ☐ Hunting
- ☐ Bike
- ☐ Drug Abuse
- ☐ Alcohol Abuse
- ☐ No alcohol or drug abuse
- ☐ Other...

Current Medicines

Current Medicines	Amount

Family History

- ☐ Blindness
- ☐ Cataracts
- ☐ Crossed Eyes
- ☐ Color Blind
- ☐ Diabetes
- ☐ Kidney Disease
- ☐ Macular Degen.
- ☐ Retina Disease
- ☐ Retina Detach
- ☐ Heart Disease
- ☐ High B.P.
- ☐ Thyroid
- ☐ Glaucoma
- ☐ Cancer
- ☐ None
- ☐ Other...

Lifestyle Questions

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

- ☐ Work at a computer often?
- ☐ Think you might benefit from thinner lenses?
- ☐ Would like to "test drive" the latest contact lenses?
- ☐ Spend time outdoors?
- ☐ Prefer not to wear your glasses at times?
- ☐ Want info. on Laser Vision Correction
- ☐ Have more than 1 pair of current Rx

Our office requires payment at the time of service unless we "accept assignment" on your insurance. You are responsible if your insurance doesn't pay. Should collection become necessary, I/We agree to pay all attorney's fees, court costs, filing fees, and all collection costs up to 33.33% of the amount owing which may be assessed by any collection agency retained to pursue the matter. I/We further agree to pay $2.00 every two weeks on balances over 60 days old. Contact lens fit and follow up care is billed separately from your eye exam. Your information is protected by our privacy policy.
I have received a copy of Wardell Vision Center "Notice of Privacy Practices".

Guardian:

Signature_____ Date_____

Relationship to Patient: _____

Remind me of my appointment by: ☐ Text

Exam:
____ Dilating ____Photos ____ Auto Refraction/Keratometry ____ Topography ____ Visual Fields

Glasses:
____ Frame Style/Disp. ____ Repair ____ PAL ____ Poly ____ AR ____ Trans ____ Sunglasses ____ Readers ____ Computer

Contacts:
I&R Polish