WELCOME to Main Line Vision A MEMBER OF Vision Source

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Welcome to our practice! Fill out this form as completely as possible. Please print. If you have any questions, please ask. Thanks!

PATIENT INFORMATION

Last name:	First name:	Mid. int'l:	Preferred name:	Today's date: / /	Date of birth: / /
❑ Married ❑ Single ❑ Widowed ❑ Partnered	Social Security no.: - -	Age:	❑ Mrs. ❑ Ms. ❑ Miss ❑ Mr.		Sex: ❑ M ❑ F

Street address:	Apt no.:		Phone numbers:
City:	State:	Zip:	Cell: ( )
Occupation:	Employer name and city:		Work: ( )
Email:			Home: ( )

I chose Main Line Vision because/referred by (please check boxes):

❑ Family ❑ Friend ❑ Insurance plan ❑ Internet search ❑ Close to my home / work ❑ Mailer / postcard

❑ Other (specify): Other family members seen here:

MEDICAL INSURANCE

Medical insurance subscriber is: ❑ Myself ❑ Spouse ❑ Parent

Insurance co. name: ❑ Aetna ❑ Anthem ❑ Blue Cross ❑ Cigna

❑ Golden Rule ❑ Humana ❑ Medicare ❑ United Healthcare

❑ Other (name):

Medical insurance subscriber information (if not you):

Name: Birth date: / /

Address:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at patient's address):	Relationship to patient:	Phone no.: ( )

DOCTOR INFORMATION	CONTACT LENSES	GLASSES
Previous eye doctor's name:	Do you wear contact lenses? ❑ Yes ❑ No	Do you wear glasses? ❑ Yes ❑ No If yes,
	If so, number of hours per day:	❑ Always ❑ Occasionally
Date of last eye doctor visit: / /	Brand of contacts:	❑ Computer ❑ Reading ❑ Driving ❑ TV
Family doctor's name:	Describe any problems with your contacts:	Describe any problems with your glasses:

EYE HEALTH HISTORY

Are you currently experiencing, or have you ever experienced, any of the following?			**If yes, please elaborate.**
Bloodshot Eyes	☐ Yes	☐ No	
Blurry Vision (distance)	☐ Yes	☐ No	
Blurry Vision (near)	☐ Yes	☐ No	
Burning Eyes	☐ Yes	☐ No	
Color Vision Problems	☐ Yes	☐ No	
Discharge from Eyes	☐ Yes	☐ No	
Dizzy Spells	☐ Yes	☐ No	
Double Vision	☐ Yes	☐ No	
Dry Eyes	☐ Yes	☐ No	
Floaters or Spots	☐ Yes	☐ No	
Fainting Spells	☐ Yes	☐ No	
Halos	☐ Yes	☐ No	
Headaches	☐ Yes	☐ No	
Infection	☐ Yes	☐ No	
Itching Eyes	☐ Yes	☐ No	
Light Flashes	☐ Yes	☐ No	
Light Sensitivity	☐ Yes	☐ No	
Loss of Vision	☐ Yes	☐ No	
Pain or Soreness	☐ Yes	☐ No	
Red Eyes	☐ Yes	☐ No	
Sandy or Gritty Feeling	☐ Yes	☐ No	
Tearing/Watering	☐ Yes	☐ No	
Twitching Eyelid	☐ Yes	☐ No	
Other (please describe)			

OTHER INFORMATION

Do you use alcohol?	☐ No	☐ Yes, moderate	☐ Yes, more than moderate	
Do you use tobacco?	☐ No	☐ Yes, moderate	☐ Yes, more than moderate	
Are you pregnant?	☐ No	☐ Yes		
Have you had eye surgery?	☐ None	☐ RK	☐ PRK	☐ Lasik ☐ Cataract
	☐ Other surgery (specify):			

MEDICATIONS

Please list any medications that you are currently taking, including eye drops.

Pharmacy name: ( )

Pharmacy phone: ( )

ALLERGIES

Please list your allergies to medications or other substances:

EYE CONDITIONS

Have you or a family member experienced, or been treated for, any of the following?

Condition	Yourself		Family member		Relationship to family member
Cataracts	☐ Yes	☐ No	☐ Yes	☐ No	
Crossed Eye	☐ Yes	☐ No	☐ Yes	☐ No	
Diabetic Retinopathy	☐ Yes	☐ No	☐ Yes	☐ No	
Glaucoma	☐ Yes	☐ No	☐ Yes	☐ No	
Lazy Eye	☐ Yes	☐ No	☐ Yes	☐ No	
Macular Degeneration	☐ Yes	☐ No	☐ Yes	☐ No	
Retinal Detachment	☐ Yes	☐ No	☐ Yes	☐ No	

GENERAL HEALTH

Have you or a family member experienced, or been treated for, any of the following?

Condition	Yourself		Family member		Relationship to family member
Allergies	☐ Yes	☐ No	☐ Yes	☐ No	
Arthritis	☐ Yes	☐ No	☐ Yes	☐ No	
Asthma	☐ Yes	☐ No	☐ Yes	☐ No	
Blood/Lymph Disorder	☐ Yes	☐ No	☐ Yes	☐ No	
Cancer	☐ Yes	☐ No	☐ Yes	☐ No	
Chemical Dependency	☐ Yes	☐ No	☐ Yes	☐ No	
Diabetes	☐ Yes	☐ No	☐ Yes	☐ No	
Ear/Nose/Throat Conditions	☐ Yes	☐ No	☐ Yes	☐ No	
Gastrointestinal Conditions	☐ Yes	☐ No	☐ Yes	☐ No	
Heart Disease	☐ Yes	☐ No	☐ Yes	☐ No	
High Blood Pressure	☐ Yes	☐ No	☐ Yes	☐ No	
High Cholesterol	☐ Yes	☐ No	☐ Yes	☐ No	
Kidney Disease	☐ Yes	☐ No	☐ Yes	☐ No	
Lupus	☐ Yes	☐ No	☐ Yes	☐ No	
Migraine Headaches	☐ Yes	☐ No	☐ Yes	☐ No	
Neurological Conditions	☐ Yes	☐ No	☐ Yes	☐ No	
Pacemaker	☐ Yes	☐ No	☐ Yes	☐ No	
Psychiatric Disorder	☐ Yes	☐ No	☐ Yes	☐ No	
Respiratory Disease	☐ Yes	☐ No	☐ Yes	☐ No	
Seizures	☐ Yes	☐ No	☐ Yes	☐ No	
Shingles	☐ Yes	☐ No	☐ Yes	☐ No	
Skin Conditions	☐ Yes	☐ No	☐ Yes	☐ No	
Stroke	☐ Yes	☐ No	☐ Yes	☐ No	
Thyroid Dysfunction	☐ Yes	☐ No	☐ Yes	☐ No	
Tuberculosis	☐ Yes	☐ No	☐ Yes	☐ No	

SIGNATURE

I acknowledge that I have received a copy of Main Line Vision's Notice of Privacy Practice.

The information provided in this form is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Dr. Haak / Dr. Lochetto. I understand that I am financially responsible for any balance. I also authorize Main Line Vision to release any information required to process my claims.

Patient / Guardian signature: Date: / /