

# 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:<br>/ /         | Date of birth:<br>/ /   |
| <input type="checkbox"/> Married | <input type="checkbox"/> Single    | Social Security no.:    |          | Age:        | <input type="checkbox"/> Mrs. | <input type="checkbox"/> Ms. | Sex:<br><input type="checkbox"/> M <input type="checkbox"/> F |
| <input type="checkbox"/> Widowed | <input type="checkbox"/> Partnered | - -                     |          |             | <input type="checkbox"/> Miss | <input type="checkbox"/> Mr. |   |
| 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: <input type="checkbox"/> Myself <input type="checkbox"/> Spouse <input type="checkbox"/> Parent<br>Insurance co. name: <input type="checkbox"/> Aetna <input type="checkbox"/> Anthem <input type="checkbox"/> Blue Cross <input type="checkbox"/> Cigna<br><input type="checkbox"/> Golden Rule <input type="checkbox"/> Humana <input type="checkbox"/> Medicare <input type="checkbox"/> United Healthcare<br><input type="checkbox"/> Other (name): _____ | Medical insurance subscriber information (if not you):<br>Name: _____ Birth date: / /<br>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:<br>_____<br>Date of last eye doctor visit:<br>/ /<br>Family doctor's name:<br>_____ | Do you wear contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>If so, number of hours per day: _____<br>Brand of contacts: _____<br>Describe any problems with your contacts:<br>_____ | Do you wear glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes,<br><input type="checkbox"/> Always <input type="checkbox"/> Occasionally<br><input type="checkbox"/> Computer <input type="checkbox"/> Reading <input type="checkbox"/> Driving <input type="checkbox"/> TV<br>Describe any problems with your glasses:<br>_____ |

### EYE HEALTH HISTORY

**Are you currently experiencing, or have you ever experienced, any of the following?**

**If yes, please elaborate.**

- |                          |                              |                             |
|--------------------------|------------------------------|-----------------------------|
| Bloodshot Eyes           | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Blurry Vision (distance) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Blurry Vision (near)     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Burning Eyes             | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Color Vision Problems    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Discharge from Eyes      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Dizzy Spells             | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Double Vision            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Dry Eyes                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Floaters or Spots        | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Fainting Spells          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Halos                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Headaches                | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Infection                | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Itching Eyes             | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Light Flashes            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Light Sensitivity        | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Loss of Vision           | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Pain or Soreness         | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Red Eyes                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Sandy or Gritty Feeling  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Tearing/Watering         | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Twitching Eyelid         | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Other (please describe)  | _____                        |                             |

### OTHER INFORMATION

- |                                  |   |  |  |                                |                                   |
|----------------------------------|---|--|--|--------------------------------|-----------------------------------|
| <b>Do you use alcohol?</b>       | <input type="checkbox"/> No                             | <input type="checkbox"/> Yes, moderate | <input type="checkbox"/> Yes, more than moderate |                                |                                   |
| <b>Do you use tobacco?</b>       | <input type="checkbox"/> No                             | <input type="checkbox"/> Yes, moderate | <input type="checkbox"/> Yes, more than moderate |                                |                                   |
| <b>Are you pregnant?</b>         | <input type="checkbox"/> No                             | <input type="checkbox"/> Yes           |  |                                |                                   |
| <b>Have you had eye surgery?</b> | <input type="checkbox"/> None                           | <input type="checkbox"/> RK            | <input type="checkbox"/> PRK                     | <input type="checkbox"/> Lasik | <input type="checkbox"/> Cataract |
|                                  | <input type="checkbox"/> 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            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____                         |
| Crossed Eye          | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____                         |
| Diabetic Retinopathy | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____                         |
| Glaucoma             | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____                         |
| Lazy Eye             | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____                         |
| Macular Degeneration | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____                         |
| Retinal Detachment   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> 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                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____                         |
| Arthritis                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____                         |
| Asthma                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____                         |
| Blood/Lymph Disorder        | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____                         |
| Cancer                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____                         |
| Chemical Dependency         | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____                         |
| Diabetes                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____                         |
| Ear/Nose/Throat Conditions  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____                         |
| Gastrointestinal Conditions | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____                         |
| Heart Disease               | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____                         |
| High Blood Pressure         | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____                         |
| High Cholesterol            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____                         |
| Kidney Disease              | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____                         |
| Lupus                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____                         |
| Migraine Headaches          | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____                         |
| Neurological Conditions     | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____                         |
| Pacemaker                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____                         |
| Psychiatric Disorder        | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____                         |
| Respiratory Disease         | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____                         |
| Seizures                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____                         |
| Shingles                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____                         |
| Skin Conditions             | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____                         |
| Stroke                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____                         |
| Thyroid Dysfunction         | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____                         |
| Tuberculosis                | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> 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. Locketto. 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:     /     /