HUNTER
Family Vision
Focused on You

WELCOME TO OUR OFFICE

Today's Date _____

Patient Information

Last Name _____
First Name _____MI_____
Date of Birth _____Age _____ Sex M F
Patient's SSN_____
Street Address_____
City _____State _____ Zipcode_____
Home Phone _____
Cell Phone _____
Work Phone _____
Email Address _____
Employer (or school)_____
Occupation (or grade)_____
Spouse or Parent's Name_____
Spouse or Parent's Work_____

What is the major purpose of this visit?

_____

Are you experiencing any problems with your current glasses or contact lenses?

_____
_____

NEW PATIENTS ONLY: VERY IMPORTANT

Who may we thank for referring you to our office?
Name of friend or relative _____
If not referred, how did you choose our office?

- ☐ Another Dr. _____
- ☐ Insurance List
- ☐ Saw Sign/ Building
- ☐ Newspaper/Radio/TV
- ☐ Yellow Pages: Which directory? _____
- ☐ Website: Which one? _____
- ☐ Other: _____

The mission of Hunter Family Vision is to contribute to a lifetime of healthy vision, providing each patient with the highest quality vision care and consequent quality of life. We will seek education to remain at the forefront of our profession and will offer the latest eye care technology, professional services, and products. The visual needs and wellness of each patient will always be our first priority. Everything we do shall communicate this.

INSURANCE INFORMATION

Please note that most insurance plans do NOT cover the Contact Lens Evaluation

Vision Insurance _____
Subscriber Name _____
Subscriber SSN _____
Subscriber Birth Date _____

Primary Medical Insurance _____
Subscriber Name _____
Subscriber SSN _____
Subscriber Birth Date_____

Do you participate in a flex spending account?
☐ Yes ☐ No
How will you settle your account today?
☐ Cash ☐ Check ☐ Credit Card

Lifestyle Questions

Do you... (check boxes if answer is yes)

- ☐...work at a computer?
- ☐...plan on purchasing new glasses today?
- ☐...think you might benefit from thinner, lighter lenses
- ☐...have an interest in a "test drive" of the latest contact lens designs
- ☐...spend time outdoors? How much? ____ Hrs/Wk
- ☐...have prescription sunwear?
- ☐...prefer not to wear your glasses at times?
- ☐...want information on Laser Vision Correction surgery
- ☐...have more than 1 pair of current Rx eyewear?
- ☐...have children?
- ☐...have family members in need of eyecare?

Have you ever experienced, been diagnosed or treated for any of the following?

- ☐ Blurry Vision
- ☐ Burning
- ☐ Cataracts
- ☐ Corneal Abrasions
- ☐ Crossed Eye/Eye Turn
- ☐ Double Vision
- ☐ Eye Infections
- ☐ Eye Injury
- ☐ Flash of Light
- ☐ Floaters/Spots
- ☐ Glaucoma
- ☐ Grittiness
- ☐ Headaches
- ☐ Iritis/Uveitis
- ☐ Itchiness
- ☐ Lazy Eye
- ☐ Macular Degeneration
- ☐ Occasional Dryness
- ☐ Retinal Detachment
- ☐ Sunlight Sensitivity
- ☐ Tearing
- ☐ Uncomfortable glasses
- ☐ Trouble Seeing at night
- ☐ Other eye disorders: _____

_____
_____

The information in this confidential case history form is critical to the evaluation of your vision and health.

Patient Medical History

Name of Family Physician_____
Location _____
Date of Last Physical Check-Up _____

Additional Physicians you see routinely for other conditions or treatments that you would like us to send your vision visits to:
Doctor Name: _____
Address:_____
Phone: _____

CURRENT MEDICATIONS (Rx or Over the Counter)
(List names of medications including eye drops, vitamins, and birth control pills)_____
_____
_____
_____

Allergies to Medications? ☐ Yes ☐ No
If so, what medications? _____
_____

Have you had any surgeries? ☐ Yes ☐ No
If yes, what _____

Do you: ☐ Drink Alcohol ☐ Use Tobacco ☐ Smoke
If so, how much or how often:_____
_____
_____

Have you ever been diagnosed or treated for the following health problems?	**Yes**	**No**
Allergies	☐	☐
Arthritis	☐	☐
Blood/Lymph	☐	☐
Bronchitis	☐	☐
Cancer	☐	☐
Cholesterol	☐	☐
Diabetes	☐	☐
Digestive	☐	☐
Ears/Nose/Throat	☐	☐
Endocrine	☐	☐
Eczema/Rashes	☐	☐
Fatigue	☐	☐
Genitourinary	☐	☐
High Blood Pressure	☐	☐
Integumentary (Skin)	☐	☐
Kidney	☐	☐
Muscle/Bone	☐	☐
Neurological	☐	☐
Psychological	☐	☐
Respiratory	☐	☐
Sinus	☐	☐
Throat Infections	☐	☐
Thyroid	☐	☐
Unusual weight losses/gain	☐	☐

Patient Eye History

Date of Last Eye Exam _____
By Whom?_____

Have you ever tried wearing contact lenses? Yes No

Do you currently wear contact lenses? Yes No
What kind? _____
Solution Used_____

Are you satisfied with the vision and comfort of your contact lenses? ☐ Yes ☐ No

Would you prefer clear contacts or colored contact lenses? ☐ Clear ☐ Colored

If you wear bifocals, do the lines or head tilting bother you? ☐ Yes ☐ No

Family Medical Eye History (Check all that apply)

Is there a family medical history of any of the following:
☐ No ☐ Yes (Please check boxes)

	Relationship (Mother or Father)
Blindness	☐_____
Cataracts	☐_____
Corneal Problems	☐_____
Diabetes	☐_____
Glaucoma	☐_____
Heart Disease	☐_____
Lazy Eye	☐_____
Macular Degeneration	☐_____
Retinal Problems	☐_____

HIPPA and Financial Acknowledgement

Please be advised if you are using insurance coverage for today's visit, this is a contract between you and your insurance company... not Hunter Family Vision.

I understand that I am financially responsible for all charges whether or not paid by insurance.

I received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Patient Signature _____

Hunter Family Vision Locations

4700 135th Street
Leawood, KS 66224
913-681-8555 (P)
913-273-6981 (Fax)

8201 Mission Rd. #104
Prairie Village, KS 66208
913-381-2323 (P)
913-273-6981 (Fax)