TRINITY VISION
WELCOME TO OUR OFFICE

Welcome to Dr. Helen Orth's office. Thank you for choosing us for your eye care needs. We are delighted to have you as a patient and appreciate the confidence you placed in us. Please take a moment to complete the following information and review all completed areas to ensure that the information we have is current and accurate.

☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms. ☐ Male ☐ Female

First Name _____ MI _____ Last Name _____ Preferred Name _____

Street Address _____ Apt# _____ City _____ State _____ Zip _____

Social Security Number _____ Date of Birth _____ Age _____ Home Phone - Include Area Code _____ Day Phone _____

Email Address _____ Guardian _____ Person Responsible for Account _____

How were you referred to our office? _____

VISION INSURANCE INFORMATION

Name and Address of Primary Insurance Company _____ City _____ State _____ Zip _____

M☐ F☐

Insured's First Name _____ MI _____ Insured's Last Name _____

Insured's Identification Number _____ Group Number _____ Insured's Date of Birth _____

Patient Relationship to Insured
☐ Self ☐ Spouse ☐ Child ☐ Other

Patient Status
☐ Single ☐ Married ☐ Other
☐ Full Time Student ☐ Part Time Student ☐ Employed

MEDICAL INSURANCE INFORMATION

Name and Address of Secondary Insurance Company _____ City _____ State Zip _____

M ☐ F ☐

Insured's First Name _____ MI _____ Insured's Last Name _____

Insured's Identification Number _____ Group Number _____ Insured's Date of Birth _____

Patient Relationship to Insured
☐ Self ☐ Spouse ☐ Child ☐ Other

Please Read:

In order to control the cost of billing, we ask that the patient's portion is paid at the time services are rendered unless other arrangements are made in advance. We would rather control billing costs than be forced to raise our fees. All professional services and material are charged to the patient.The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Accounts 90 days old are subject to collection fees. There will be a service charge on all returned checks.

Payment from my insurance is to be paid directly to . I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed.

I Acknowledge That A Copy Of Privacy Practices Has Been Made Available To Me.

Signature _____ Date _____

PATIENT HISTORY AND INFORMATION

What is the main reason for today's exam? _____

When was your last eye exam? _____

Do you currently wear glasses? ☐ Yes ☐ No

Do you wear prescription sunglasses? ☐ Yes ☐ No

Are you interested in trying contact lenses today? ☐ Yes ☐ No

Do your eyes sting, burn, itch, or Feel dry? ☐ Yes ☐ No

Do you have eyestrain when using a computer or on electronic devices? ☐ Yes ☐ No

Do you have diabetes? ☐ Yes ☐ No

Past Eye Illnesses/Injuries/surgeries _____

_____

Current Medications and eye drops:_____

_____

Medications you are allergic to: _____

Please check if you have these conditions:

EYE HISTORY

- ☐ Glaucoma
- ☐ Cataract
- ☐ Macular Degeneration
- ☐ Retinal Detachment
- ☐ Amblyopia (Lazy Eye)
- ☐ Mucous Discharge
- ☐ Redness
- ☐ Dryness
- ☐ Tearing/Watering
- ☐ Sandy/Gritty Feeling
- ☐ Itching
- ☐ Light Sensitivity
- ☐ Eye Pain
- ☐ Blurred Vision
- ☐ Headache
- ☐ Tired Eyes/soreness
- ☐ Double Vision
- ☐ Fluctuating or loss of vision
- ☐ Other:_____

GENERAL HEALTH CONDITION

- ☐ Diabetes
- ☐ Thyroid
- ☐ High blood pressure
- ☐ High Cholesterol
- ☐ Respiratory (Asthma)
- ☐ Gastrointestinal
- ☐ Rheumatoid Arthritis
- ☐ Skin conditions
- ☐ Neurological (Multiple Sclerosis)
- ☐ Anxiety or Depression
- ☐ Other:_____

FAMILY HISTORY

- ☐ Blindness
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Retinal disorders
- ☐ Other:_____

SOCIAL HISTORY

Do you drink alcohol? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No

Current Occupation: _____