Welcome to Fishers Family Vision Center

Please complete both sides of this informational questionnaire for Dr. Sigler

Last Name_____ First _____ Middle_____ Date of Birth_____

Address_____ City, State, Zip_____

Home phone_____ Work_____ Cell_____ E-mail_____

Employer_____ Occupation_____

How did you hear about us?_____ List other family members who are patients here_____

Do you plan on ordering glasses or contact lenses today? _____

Please describe any problems you are experiencing with your eyes or vision: blurry ☐ pain ☐ red ☐ tired ☐ spots ☐ double vision ☐

headaches ☐ dry ☐ burn ☐ watery ☐ other :_____

When was your last eye exam?_____ Where?_____

Do you wear glasses now? Yes ☐ No ☐ If so, when do you need them most?_____

Do you wear contact lenses? Yes ☐ No ☐ If so, what type? hard ☐ soft yearly ☐ soft quarterly ☐ soft monthly ☐ soft 2 week ☐

soft daily ☐ toric ☐ bifocal ☐ tinted ☐ Brand name, power, base curve:_____

Do you sleep in your contacts?_____ If so, how many nights in an average month?_____

What solutions do you use?_____ Are you allergic to any contact lens products?_____

List any past eye surgeries, injuries, or infections:_____

Are you interested in refractive surgery or LASIK? Yes ☐ No ☐ Maybe ☐ I have already had refractive surgery on:_____

Are you diabetic? No ☐ Yes ☐ If yes, list most recent plasma glucose _____ & most recent A1C _____

List any medical conditions you have: Heart Disease ☐ High blood pressure ☐ Multiple Sclerosis ☐ Arthritis ☐ Thyroid disorder ☐

Cancer ☐ other:_____

List any infectious disease you may have: Cold ☐ Flu ☐ other:_____

List any eye diseases that run in your family: Cataracts ☐ Glaucoma ☐ Macular degeneration ☐ other:_____

List any major medical conditions that run in your family: Heart Disease ☐ High blood pressure ☐ Multiple Sclerosis ☐ Arthritis ☐

Thyroid disorder ☐ Cancer ☐ other:_____

List any medications you are currently taking (including non-prescription medications):_____

List any medical allergies:_____

List any environmental or food allergies: _____

Do you smoke? Yes ☐ No ☐ If so, how many packs/day?_____ Do you drink alcohol? Never ☐ Seldom ☐ Occasionally ☐ Often ☐

Females, are you pregnant? Yes ☐ No ☐ If so, how many months?_____

Have you ever been diagnosed with a learning disability? _____

Fishers Family Vision Center is committed to maximizing your quality of life by meeting your visual needs. We can only meet your needs if we know what they are! Please take a moment to let us know if you have any special visual demands:

☐ **Driving**	☐ **School**	☐ **Reading**	☐ **Computer**	☐ **Sports**
☐ **Safety**	☐ **Swimming**	☐ **Flying**	☐ **Sewing**	☐ **Occupational**
☐ **Crafts**	☐ **Art**	☐ **Music**	☐ **Fashion**	☐ **Other**_____

Do you have any questions about any particular eye care, contact lens, eyeglass lens or frame option:

☐ **Bifocal contacts**	☐ **Tinted contacts**	☐ **Extended wear**	☐ **Contact solutions**	☐ **No-line bifocal**
☐ **Anti-glare coating**	☐ **Transition lenses**	☐ **Polarized lenses**	☐ **Bendable frames**	☐ **Sun-clips**
☐ **Eye drops**	☐ **Sport goggles**	☐ **Other**_____		

Do you have any questions about any eye care product that you may have seen advertised?_____

_____

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Major Medical Insurance Company:_____ID#_____

****Many Major Medical policies cover routine vision care, however they may have contracts with other insurance companies that specialize in eye care to administer this portion of the coverage. In order to file eye care claims promptly and accurately, we need to know the name of the company that administers your vision plan. Members can obtain this information from their health insurance information packets, or from their health insurance customer service representative. Members may also obtain this information from their employer's human resources department.

Vision Insurance Company:_____ID#_____

****I authorize the release of any medical or other information necessary to process my vision claim. I also authorize payment of insurance benefits to the Fishers Family Vision Center, Inc. for services rendered. I understand that any balance unpaid by my insurance carrier is my complete responsibility. I further acknowledge that I will be responsible for reasonable collection fees, attorney fees, and court costs incurred in any attempt by this office to collect unpaid balances.

Patient's signature_____date_____

Printed name_____

If patient is a minor, responsible party's signature_____

Relationship to patient_____

Updated date_____ initials_____ Updated date_____ initials_____

Updated date_____ initials_____ Updated date_____ initials_____

Updated date_____ initials_____ Updated date_____ initials_____

Thank you for your understanding and cooperation.