WELCOME
New Patient Form

307 Vision

PATIENT INFORMATION

Date: _____ SSN: _____ Date of Birth: _____

First Name: _____ Middle Initial: _____ Last Name: _____

Parent/Guardian Name (if patient is a minor):_____

Address:_____

City: _____ State: _____ Zip: _____

Phone: _____ May we leave confidential messages at this number? ☐ Yes ☐ No

May we text an appointment reminder to this number? ☐ Yes ☐ No

Email: _____ May we contact you via email? ☐ Yes ☐ No

Occupation/Employer: _____ Work Phone: _____

Vision Insurance:_____ Medical Insurance: _____

Is any other family member a patient in our office?: _____

Whom may we thank for referring you? _____

Who is responsible for payment of services?_____

Payers Phone Number (if different from patient):_____

Payers Address (if different from patient):_____

City: _____ State: _____ Zip: _____

MEDICAL INFORMATION

Medical Doctor: _____ Date of last exam: _____

Main reason for your visit today: _____

Do you wear glasses? ☐ Yes ☐ No If yes, how old are your lenses? _____

Do you wear contacts? ☐ Yes ☐ No If yes, what type and how old are your lenses? _____

Are you interested in: ☐ Glasses ☐ Laser Vision Correction

☐ Contacts ☐ Eye Health Nutritional Supplements

Do you have allergies to medications?: ☐ Yes ☐ No If yes, explain: _____

Do you have other allergies (environmental/seasonal)?: ☐ Yes ☐ No If yes, explain: _____

Please list all medications currently taken: _____

Do you use tobacco products? ☐ Yes ☐ No If yes, type/amount/how long? _____

Do you drink alcohol? ☐ Yes ☐ No If yes, type/amount/how long? _____

Do you use illegal drugs? ☐ Yes ☐ No If yes, type/amount/how long? _____

Are you currently pregnant? ☐ Yes ☐ No Are you currently nursing? ☐ Yes ☐ No

Ph: (307) 266-9988

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Casper, WY 82609

Fax: (307) 266-9992

MEDICAL HISTORY (PERSONAL & FAMILY)

OCULAR

Crossed Eyes	☐ Self	☐ Family	Relationship to Patient: _____
Lazy Eye	☐ Self	☐ Family	Relationship to Patient: _____
Cataract	☐ Self	☐ Family	Relationship to Patient: _____
Glaucoma	☐ Self	☐ Family	Relationship to Patient: _____
Macular Degeneration	☐ Self	☐ Family	Relationship to Patient: _____
Retinal Disease	☐ Self	☐ Family	Relationship to Patient: _____
Other: _____	☐ Self	☐ Family	Relationship to Patient: _____

Have you ever had any type of eye injury or eye surgery? ☐ Yes ☐ No

If Yes, please explain: _____

CARDIOVASCULAR

Heart Disease	☐ Self	☐ Family	Relationship to Patient: _____
High Blood Pressure	☐ Self	☐ Family	Relationship to Patient: _____
Heart Attack	☐ Self	☐ Family	Relationship to Patient: _____
Stroke	☐ Self	☐ Family	Relationship to Patient: _____

ENDOCRINE

High Cholesterol	☐ Self	☐ Family	Relationship to Patient: _____
Diabetes	☐ Self	☐ Family	Relationship to Patient: _____
Kidney Disease	☐ Self	☐ Family	Relationship to Patient: _____
Thyroid Disease	☐ Self	☐ Family	Relationship to Patient: _____

GASTROINTESTINAL

GERD	☐ Self	☐ Family	Relationship to Patient: _____
Crohn's Disease	☐ Self	☐ Family	Relationship to Patient: _____
Liver Disease	☐ Self	☐ Family	Relationship to Patient: _____

HEMATOLOGICAL/LYMPHATIC

Anemia	☐ Self	☐ Family	Relationship to Patient: _____
Clotting Disorder	☐ Self	☐ Family	Relationship to Patient: _____
Sickle Cell	☐ Self	☐ Family	Relationship to Patient: _____

IMMUNOLOGIC

Herpes Simplex	☐ Self	☐ Family	Relationship to Patient: _____
Herpes Zoster	☐ Self	☐ Family	Relationship to Patient: _____
HIV/AIDS	☐ Self	☐ Family	Relationship to Patient: _____
Sarcoidosis	☐ Self	☐ Family	Relationship to Patient: _____

MEDICAL HISTORY (PERSONAL & FAMILY) CONTINUED

RESPIRATORY

Asthma	☐ Self	☐ Family	Relationship to Patient: _____
Cystic Fibrosis	☐ Self	☐ Family	Relationship to Patient: _____
Emphysema	☐ Self	☐ Family	Relationship to Patient: _____

MUSCULOSKELETAL

Arthritis	☐ Self	☐ Family	Relationship to Patient: _____
Ankylosing Spondylitis	☐ Self	☐ Family	Relationship to Patient: _____
Myasthenia Gravis	☐ Self	☐ Family	Relationship to Patient: _____

SKIN

Rosacea	☐ Self	☐ Family	Relationship to Patient: _____

NEUROLOGICAL

Headache/Migraine	☐ Self	☐ Family	Relationship to Patient: _____
Acquired Brain Injury	☐ Self	☐ Family	Relationship to Patient: _____
Multiple Sclerosis	☐ Self	☐ Family	Relationship to Patient: _____

PSYCHIATRIC

Attention Disorder	☐ Self	☐ Family	Relationship to Patient: _____
Alzheimer's	☐ Self	☐ Family	Relationship to Patient: _____
Depression	☐ Self	☐ Family	Relationship to Patient: _____

Please list any other condition(s) you have that are not found above: _____

_____

PAYMENT INFORMATION

As a courtesy, we file Medicare, Medicaid, and most health insurances. Please inform us of any medical or vision insurance coverage before your exam so we can verify benefits and coverage at the time of service. Verification of coverage is not a guarantee of payment from your insurance company.

Payment is due at the time of service and before contacts can be ordered. This includes all insurance co-pays. If needed, we accept half down with the remaining balance due before the contact lenses can be dispensed. In the event of non-payment to 307 Vision, a $6.00 billing fee per month will be assessed. Accounts that are assigned to an agent for collection with additionally be assessed a 35% fee on any unpaid balance.

Signature: _____ Date: _____