Village Vision Care

Independent Optometrists inside COSTCO™

Toledo, OH • Perrysburg, OH • Ann Arbor, MI • Livonia, MI • Bloomfield, MI

Today's Date: _____

Patient Information

Last Name: _____ First Name: _____ Middle Initial:____ Date: ____/____/____ M □ F □

Address: _____City:_____ State: _____ Zip: _____

Phone: _____ Cell □ Home □ Work □ Marital Status: S □ M □ D □ W □

Phone: _____ Cell □ Home □ Work □ Occupation: _____

Email address: _____ Employer: _____

Medical and Vision History

What is the reason for today's exam? _____ Primary Care Physician: _____

Date of last eye exam: _____/_____ When? Where? _____ May we contact them for Rx info? Yes □ No □

Do you currently wear? Glasses □ Contacts □ Neither □ Age of glasses: _____

Are you interested in? Glasses □ Contacts □ LASIK □ Do you use a computer? Yes □ No □

Do you have difficulty driving at night? Yes □ No □ Do you have trouble with glare? Yes □ No □

Do you work under fluorescent lights? Yes □ No □ Do you require special eye protection (sports/work)? Yes □ No □

Do you use tobacco? Yes □ No □ Former □ if yes how much?_____
Do you use alcohol? Yes □ No □ Social □ Dependency □

For Contact Lens WEARERS ONLY:

What type or brand of contacts do you wear? _____

Age of current pair? _____ How often do you replace your contacts?_____

Do you sleep in your contacts? Yes □ No □ If yes, how frequently?_____

Disinfection method: RENU□ OPTIFREE□ BIOTRUE□ CLEAR CARE□ OTHER□ STORE BRANDS□

Any complaints of the contacts you wear? None □ _____

Please continue to the back page » » »

Please check (√) all that apply to you or your family (parents, siblings, or grandparents):

	Self	Family	None		Self	Family	None
Lazy Eye / Wandering Eye				Autoimmune: Rheumatoid Arthritis / Lupus / MS			
Cataracts				Cancer (Type:_____)			
Color Blindness / Deficiency				Diabetes			
Double Vision				Headaches / Migraines			
Dry Eye / Watery Eyes				Heart Problems			
Eye Injury / Trauma				Hepatitis			
Eye/ Lids Surgery				HIV / AIDS			
Floaters / Flashes of Light				High Blood Pressure			
Glaucoma				High Cholesterol			
Macular Degeneration				Respiratory Problems			
Retinal Detachment/ Disease				Thyroid Disease			
Vision Loss / Blindness				Currently Pregnant			

Please list any other **medical conditons**:_____

_____

Please list any **eyedrops** you are using (including over-the-counter)? None □ _____

Please list any **medications** you are using (including over-the-counter)? None □ _____

_____

_____

Please list any **allergies** you have (including medications and environmental)? None □ _____

_____

I have read and reviewed the prominently posted HIPAA privacy disclosure for Village Vision Care. Yes □ No □
Privacy notice copy available upon request.

Signature: _____ □ Self □ Parent / Guardian □ Care Giver

Please check if you are self-pay ____ or using insurance ____ today. Contact lens fitting fees are not typically covered by insurances. We are direct providers for many vision care plans, but not all. Our staff will help with insurance questions, eligibility, forms, and prior authorizations. We are not providers for Medicare or Medicaid Plans.

Note: This encounter form and all patient protected health, personal, or private information is shredded after exam.