Ted M. Smiley, O.D., Patrick Dollenmayer, O.D.

Welcome back to our office! Please help us to update your files so we can provide the best services possible.

Name:____ Responsible Party:____

Current Address: ____City: ___________________ Zip:_____________

Home Phone: _____________________ Work Phone:_____________________ Cell Phone:_______________________

Please Circle Preferred Contact Number

Email: ____

Occupation: ____ Employer: ____________________________________

Current Medical Insurance:______________________________ ID#: ____

Please Present Medical Insurance Card

Current Vision Insurance:_______________________________ ID#: ____

Health History

Are you experiencing: Y/N

Blurred Vision? _____ Eye Discomfort? ______ Frequent Headaches? _____ Dry or Watery Eyes? _____

Current Medications:____

____

____

Any hospitalizations since last visit?____

Are you interested in discussing refractive surgery today? ____

Do you wear contact lenses? _____________ Are you interested in Contact Lenses today?_________________________

Date of Last Eye Examination (if not in our office) ____

Thank you for entrusting the health of your eyes to us. Our commitment is to provide you with the highest standards of care. To help us best serve you best, **please answer the questions below** so we can learn more about your vision and how you use your eyes. Our highly trained staff will use this information to provide a vision solution that meets your needs.

Do you wear glasses or contact lenses all day?	Yes ____	No_____
Do you experience difficulty with nighttime driving?	Yes____	No_____
Are you in and out of sunlight throughout the day?	Yes____	No_____
Do you need bifocal correction, but dislike having a bifocal line on your lenses?	Yes____	No_____
Are you experience eyestrain, vision fatigue, or headaches? (Please Circle)	Yes____	No_____

How many hours a day do you spend on the computer or with hobbies that require close vision? _______Hours

I have read the office policies and understand my financial obligations. I also acknowledge I have been offered a copy of the Columbus Eyecare Associates, Inc. privacy practices.

Signature of Responsible Party: ____ Date:___________________