CARILLON visioncare

Welcome To Our Office

Drs. Christina DalPorto,
Andrew Neukirch, & Assoc.

We are pleased to have you as a part of our practice. The following information will aid our doctors in providing the most complete care possible.
If you are a returning patient, please only fill out information that may have changed.

Patient Information

Date _____

Name _____

Address _____

City _____ State _____ Zip _____

Phone (Home) _____

Phone (Work) _____

Phone (Cell) _____

Email _____

Sex ❒ M ❒ F Age _____ Birth date _____

SS# _____

Employer _____

Occupation _____

School _____

Grade _____

In case of emergency, contact _____

Relationship _____

Phone _____

Payment / Insurance Information

Please circle the method of payment for today's professional services:

▫ Cash ▫ Check ▫ VISA/MC ▫ DISCOVER

Who is responsible for this account _____

Relationship to the Patient _____

Insurance Company _____

Group # _____

Subscriber's Name _____

Birth date _____ SS# _____

Assignment and Release

I certify that I, and/or my dependents have insurance coverage with

_____ and assign directly to Carillon Vision Care
[Name of Insurance Company(ies)]

all insurance benefits, if any, otherwise payable to me for services/materials rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Carillon Vision Care may use my health care information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services/ materials and determining insurance benefits or the benefits payable for related services/materials. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Print Name of Patient, Parent, Guardian or Personal Representative

_____
Signature of Patient, Parent, Guardian or Personal Representative

Date _____ Relationship _____

Eye / Vision Concerns

Date of last exam _____ Doctor's Name _____

Reason for Today's Visit:

- ❒ Annual Check-up, Not Having Any Problems
- ❒ Need Stronger Prescription for Distance of Near Tasks
- ❒ Need Bifocals or Reading Spectacles
- ❒ Replace Lost or Broken Spectacles
- ❒ Need Second Pair Spectacles or Sunglasses
- ❒ Need More Contact Lenses
- ❒ Would Like to Try Contact Lenses
- ❒ Need Reading Glasses Over Contact Lenses
- ❒ Trouble Using Eyes Comfortably
- ❒ Other _____

Do you wear glasses? ❒ Yes ❒ No

❒ All the time ❒ Occasionally
❒ Distance tasks ❒ Near Tasks ❒ Computer

Do you wear contacts? ❒ Yes ❒ No Type _____ Replacement Schedule _

Hours/Day Worn _____ Pairs Left _____ Solutions _____

To get a better sense of how you use your eyes, are there any hobbies, sports, or other recreational activities you participate in on a regular basis?

_____

Please place a "√" in any ❒ to indicate if you are experiencing any of the following.

- ❒ Blurred Vision – Distance
- ❒ Blurred Vision – Near
- ❒ Burning Eyes
- ❒ Cataracts
- ❒ Crossed Eyes
- ❒ Crusty Eyelids
- ❒ Discharge from Eyes
- ❒ Dizzy Spells
- ❒ Double Vision
- ❒ Dry Eyes
- ❒ Eye Infections
- ❒ Eye Injury
- ❒ Eye Strain
- ❒ Fainting Spells, Blackouts
- ❒ Floaters or Spots
- ❒ Fluctuating Vision
- ❒ Glaucoma
- ❒ Headaches
- ❒ Itching Eyes
- ❒ Light Sensitivity
- ❒ Loss of Vision
- ❒ Macular Degeneration
- ❒ Migraine Headaches
- ❒ Poor Night Vision
- ❒ Red Eyes
- ❒ Seeing Flashes
- ❒ Seeing Halos
- ❒ Styes
- ❒ Temporary Loss of Vision
- ❒ Tired Eyes
- ❒ Twitching Eyelid
- ❒ Watering Eyes

— OVER —

Health History

Date of your last physical _____ Physician's name _____

Please place a "√" in any ❒ to indicate if you have had any of the following. Also, place a "√" in any ❒ to indicate if a blood relative has had any of the following problems (including parents, grandparents, uncle, aunts or siblings).

	Yourself	Family Members
AIDS/HIV	❒	❒
Anemia	❒	❒
Anxiety	❒	❒
Arthritis	❒	❒
Asthma	❒	❒
Blindness	❒	❒
Brain Tumor	❒	❒
Cancer	❒	❒
Cataracts	❒	❒
Chemical Dependency	❒	❒
Depression	❒	❒
Diabetes	❒	❒
Drug Sensitivity	❒	❒
Emphysema	❒	❒
Epilepsy	❒	❒
Eye Surgery	❒	❒
Glaucoma	❒	❒
Graves Disease	❒	❒
Hay Fever	❒	❒
Head Injury	❒	❒
Heart Condition	❒	❒
Hepatitis (Type _____)	❒	❒
Herpes	❒	❒

	Yourself	Family Members
High Blood Pressure	❒	❒
High Cholesterol	❒	❒
Kidney Disease	❒	❒
Lazy Eye or Turned Eye	❒	❒
Lupus	❒	❒
Macular Degeneration	❒	❒
Migraine Headaches	❒	❒
MultipleSclerosis	❒	❒
Myasthenia Gravis	❒	❒
Pacemaker	❒	❒
Retinal Detachment	❒	❒
Sickle Cell or Trait	❒	❒
Shingles	❒	❒
Skin Disorder	❒	❒
Thyroid Condition	❒	❒
Ulcers	❒	❒
Vision Training	❒	❒

Are you pregnant? ❒ Yes ❒ No Number of children _____

Do you use tobacco? ❒ Yes ❒ No

Do you use alcohol? ❒ Yes ❒ No

ALLERGIES

Please place a "√" in any ❒ to indicate if you have any sensitivities or allergies in the categories below.

- ❒ Drugs (Please List) _____
- ❒ Foods (Please List) _____
- ❒ Environmental / Seasonal (Please include which season bothers you most) _____

MEDICATIONS / VITAMINS / SUPPLEMENTS

Please place a "√" in any ❒ to indicate if you use any prescribed or over-the-counter substances in the categories below.

- ❒ Eye Drops (Please List) _____
- ❒ Medications (Please List) _____
- ❒ Vitamins / Supplements (Please List) _____

— Thank You —