The Eye Institute of Reston

DOCTORS OF OPTOMETRY

WELCOME TO OUR OFFICE

Full Name _____

Address _____

Email Address _____

Contact Phone _____ Work Phone _____

Vision Insurance _____

Medical Insurance _____

Policy Holder Name _____

Sex: M _____ F _____

City _____ State _____

Zip _____ Date _____

Last 4 SSN _____

DOB of Policy Holder _____

Last 4 SSN of Policy Holder _____

- Do you or have you worn glasses? **Yes** **No**
- Do you smoke? **Yes** **No**
- Do you use other substances? **Yes** **No**
- Have you had laser vision corrective surgery? **Yes** **No**
- Do you have an allergies? **Yes** **No**
  if yes, please specify _____

_____

- Are you pregnant? **Yes** **No**
- Do you drink alcohol? **Yes** **No**
- When was your last eye exam?
  please specify _____
- Name any vitamins or medications:

_____

- Have you been exposed or infected by the following: **Yes** **No**
  HIV _____ *Syphilis* _____ *Hepatitis* _____ *Gonorrhea* _____

Your reason for visiting us today: Check all that apply

- ☐ General Exam
- ☐ Lost/Broken Glasses
- ☐ Blurred Distance Vision
- ☐ Blurred Near Vision
- ☐ Spots, flashes, glare
- ☐ Eyes Feel Tired
- ☐ Pain in the Eyes
- ☐ Headaches
- ☐ Dry Eye Evaluation
- ☐ Myopia Management
- ☐ Want contact lenses
- ☐ Problems with Current Contacts
- ☐ Other: _____

General History: Past or Present

- ☐ Gastrointestinal
- ☐ Ear/Nose/Throat
- ☐ Cardiovascular
- ☐ Respiratory
- ☐ Nervous System
- ☐ Genitourinary
- ☐ Musculoskeletal
- ☐ Skin
- ☐ Blood/Lymph
- ☐ Endocrine (Glands)
- ☐ Surgeries: _____

I hereby authorize this vision care provider to apply for benefits on my behalf for covered services rendered by them. I also assume my benefits and request that all payments from my insurance be made directly to the Eye Institute of Reston. I agree to assume responsibility for full payment pending any remaining balance that is not covered by my insurance.

I certify the information I have reported with regard to my coverage is correct. I further authorize The Eye Institute of Reston to release to my insurance and its agents any information related to this or any related claim

_____ _____

Signature **Date**

***I declare that I have read this consultation form thoroughly and I understand every question asked. All of the given answer is correct and true to the best of my knowledge.**

_____ _____

Signature **Date**