ADVANCED VISION CARE

14140 Meridian Parkway, Suite 101 Riverside, CA 92518
Phone 951-243-3337, Fax 951-243-6868, Email reception@avceyecare.net

Are you experiencing any flu-like/cold-like symptoms, coughing, fever over 100F, loss of sense of taste/smell, or have a flu/ cold, or exposed to a positive test COVID-19 individual? **Yes / No**
If yes, please let us know, email us, text, or call us at 951-243-3337 to reschedule your appointment until you are better.

PATIENT QUESTIONNAIRE FORM

Please circle one: New Patient/ Returning Patient Appt. Date: _____Day _____ Appt. Time: _____

Last name _____ First name _____ MI _____

Address _____ City _____ State _____ Zip _____

Cell phone (____) _____Email_____Occupation_____
DOB _____ Employer _____Medical Ins_____
Name of Vision Insurance _____Primary's ID/Social _____
Any secondary vision insurance?_____Referred by_____
Emergency Contact Name _____Phone number (____) _____
Date of last eye exam _____Were Pupils Dilated? Yes / No Were Retina Photos done? Yes/ No

Medical Information

How is your general health? _____
Do you have problems with any of these systems? (**Please circle yes or no**)

Gastrointestinal	Yes / No	Neurological	Yes / No	Endocrine	Yes / No
Ears/Nose/Throat	Yes / No	Urinary	Yes / No	Blood/lymph	Yes / No
Cardiovascular	Yes / No	Muscles/bones	Yes / No	Allergic/immunologic	Yes / No
Respiratory	Yes / No	Integumentary/skin	Yes / No	Cancer/ Type?_____	Yes/ No
High blood pressure	Yes / No	Eyes	Yes / No	High Cholesterol	Yes/ No

Please explain _____
Diabetes Yes / No Type _____Date of dagnosis_____
Allergies to medication? Yes / No Which? _____Reactions? _____
Other health problems _____
Current medication(s) _____
Have you ever had any operations? Yes / No What kind? _____ When? _____
Name of family doctor _____ Date of last visit _____
Are you pregnant? Yes / No Are you nursing? Yes / No Are you trying to get pregnant? Yes/ No
Do you smoke? Yes/ No Do you drink alcohol? Yes/ No

Family History

High blood pressure	Yes / No	Relation _____	Macular degeneration	Yes / No	Relation _____
Diabetes	Yes / No	Relation _____	Retinal detachment	Yes / No	Relation _____
Glaucoma	Yes / No	Relation _____	Cataracts	Yes / No	Relation _____

Personal Eye Information

Are you interested in (circle): Eyeglasses/ Sunglasses/ Contact Lenses/ Lasik Info/ Safety Rx/ Sport goggles rx/

_____

Are you having any problems with your vision that made you come in? _____

Do you have any eye conditions or problems? Yes / No What kind? _____

Have you had any eye operations? Yes / No Type _____ Date_____

Have you had an eye injury? Yes / No What kind _____Date_____

Do you have glaucoma?	Yes / No	Cataracts?	Yes / No	Dry eyes?	Yes / No
Macular degeneration?	Yes / No	Retinal detachment?	Yes / No	Blurred vision?	Yes / No
Do you wear glasses?	Yes / No	Uncomfortable glasses?	Yes / No	Corneal abrasion?	Yes / No
Eye infection?	Yes / No	Iritis/uveitis?	Yes / No	Lazy eye?	Yes / No
Other eye disorders?	Yes / No	Headaches?	Yes / No	Itchiness?	Yes / No
Burning?	Yes / No	Double vision?	Yes / No	Grittiness?	Yes / No
Tearing?	Yes / No	Trouble seeing at night?	Yes / No	Flashes of light?	Yes / No
Sunlight sensitivity?	Yes / No	Crossed eye/eye turn?	Yes / No	Floaters/spots?	Yes / No

Additional information _____

If You Are A Contact Lens Wearer

What brand? _____Power? R:_____L:_____BC_____

Which solution do you use? Optifree PureMois t/ BioTrue / Revitalens/ ClearCare / Generic / _____

Average amount of time wearing (hours/day)? 8 / 10 / 12 / 14 / 16 / Other _____

Do you rub your contacts when you clean them? Yes / No

How often do you dispose of your contacts? 1 Day/ 2 weeks / 1 month / 3 mos / 6 mos/ Yearly / _____

Do wear contacts while sleeping? Yes / No If yes, how many days a week? _____

If you wear contact lenses, are you satisfied with the vision and comfort? Yes / No

Retina Imaging/ Optomap is a non-invasive procedure that allows the doctor to see a broader and more detailed view of the retina. It is recommended yearly to check the internal eye health (retina, optic nerve) without dilating your pupils, no long wait time, less contact, would you like to do the test? There is a $39 fee/copay for the procedure. **Yes / No**

Pupil dilation or dilated fundus exam is covered as part of your comprehensive eye exam. It utilizes eye drops to allow the doctor to check the internal eye health. The side effects are blurred near vision and sensitivity to light for 4-6 hours. We recommend bringing a driver for this test. If you prefer not to get a dilation, we recommend doing the retina imaging. Would you like to be dilated at your eye exam appointment? **Yes / No**

HIPAA Privacy Notice/ Acknowledgement of Receipt of Privacy Notice

By signing this acknowledgement of Receipt of Notice of Privacy Practices (the "Notice"); I acknowledge that I have been provided with a copy of the Notice of Privacy for review and to keep for my records on the date signed below. Paperless copy of the notice is available at our website at www.avceyecare.net.

I understand that the Location may use and disclose necessary personal health information (for example, my name, address, subscriber identification number, eye exam information and/or types of products provided) to another party to permit the Location to perform its administrative duties, provide me with eye care services (including referral to another provider/specialist as needed for my treatment) and products, process my benefit claims and communicate with me regarding vision care services provided by the Location (for example, mailings of exam reminders or information about vision services/products provided by the Location).

I can be assured that this Location does not sell my personal health information of any kind to the third party for such party's own use. I authorize the Location to submit my vision benefit claims to my plan sponsor or health plan to receive reimbursement directly for the vision services and products that I have received from this Location.

_____ _____

Patient Signature or Patient's Legal Representative **Date**