TO BE COMPLETED BY PATIENT

PATIENT HISTORY

☐ Male ☐ Female ☐ It's okay to text me for appointment confirmation only

NAME: (Last, First) _____ **DOB:** _____ **AGE:** _____

ADDRESS: _____ **City**_____ **Zip**_____

PHONE# CELL: _____ **WORK#:** _____ **HOME#:** _____

EMAIL: _____ **OCCUPATION:** _____

INSURANCE INFORMATION

SOCIAL SECURITY NUMBER (for insurance purposes only) _____

PRIMARY VISION INSURANCE:_____
☐SUBSCRIBER
☐DEPENDENT

SECONDARY VISION INSURANCE: _____
☐SUBSCRIBER
☐DEPENDENT

PRIMARY HEALTH INSURANCE: _____
☐SUBSCRIBER ☐ HMO ☐ PPO
☐DEPENDENT

SECONDARY HEALTH INSURANCE: _____
☐SUBSCRIBER ☐ HMO ☐ PPO
☐DEPENDENT

**Subscriber's Name & DOB : _____

PRIMARY PHYSICIAN NAME: _____ **PRIMARY PHYSICIAN PHONE#:**_____

SPECIALIST(S) PHYSICIAN NAME: _____ **SPECIALIST(S) PHYSICIAN PHONE#:**_____

Do you require a referral from your Primary M.D. for specialist eye care service? _____

Note: Your major medical insurance may pay for certain eye health related services.

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign to **DWS, O.D., Inc.** all insurance benefits, if any, otherwise payable to me for services 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. ***NO REFUNDS*** are given on glasses or contacts already made by or our laboratory-remake or exchange only. All orders not dispensed within 60 days of notification ***WILL FORFEIT DEPOSIT*** unless prior arrangements are made.

PROFESSIONAL FEES DUE ON DAY OF EXAMINATION
NO REFUNDS ON CUSTOM EYEWEAR

Responsible Party Signature: _____ **Date:** _____

Relationship: _____

TURN OVER TO CONTINUE FILLING OUT FORM

WHAT IS THE REASON FOR YOUR VISIT TODAY? _____

Do you wear: □ Glasses
□ Contacts

How do you think you see far away with your current prescription? □ Clear □ Blurry

How do you think you see up close with your current prescription? □ Clear □ Blurry

Do you have eyestrain or tired eyes..... □ yes □ no

Do you have headaches from your eyes..... □ yes □ no

Do you ever see double vision..... □ yes □ no

Have you been told you have "lazy eye"..... □ yes □ no

Have you ever had an eye infection..... □ yes □ no

Have you ever had an eye injury..... □ yes □ no

Type of eye injury .....

Have you ever had any eye surgery..... □ yes □ no

Type of surgery ..... Age @ time of surgery.....

Do you have any history of cataracts in your family..... □ yes □ no

Do you have any history of glaucoma in your family ..... □ yes □ no

Do you have any history of blindness in your family..... □ yes □ no

Do you have macular degeneration in your family..... □ yes □ no

Is your color vision normal..... □ yes □ no

PLEASE CHECK ALL THAT APPLY TO YOU

□ Burning Eyes □ Dryness □ Lumps/Bumps □ Watering Eyes
□ Cross-Eyed/Wall Eyed □ Eye Infections □ Red Eyes □ Other _____
□ Discharge from Eyes □ Floaters □ Seeing Flashes
□ Dizzy Spells □ Itching Eyes □ Twitching Eyelid

HEALTH HISTORY (Circle YES if you or your family, have had any history of the following)

Condition	Yourself	Family	Condition	Yourself	Family
Arthritis	Yes	Yes	High Blood Pressure	Yes	Yes
Asthma	Yes	Yes	High Cholesterol	Yes	Yes
Cancer	Yes	Yes	Kidney Disease	Yes	Yes
Type_____			Migraine Headaches	Yes	Yes
Cardiac Conditions	Yes	Yes	Multiple Sclerosis	Yes	Yes
Diabetes	Yes	Yes	Rheumatic Fever	Yes	Yes
Drug Sensitivity	Yes	Yes	Shingles	Yes	Yes
Emphysema	Yes	Yes	Skin Conditions	Yes	Yes
Epilepsy	Yes	Yes	Stroke	Yes	Yes
Hepatitis	Yes	Yes	Thyroid	Yes	Yes
Type_____			Tuberculosis	Yes	Yes
Herpes Simplex	Yes	Yes			

DRY EYE MANAGEMENT SCALE:

Your dry eye symptoms may include: pain, burning, tearing, grittiness, "feeling like something is in your eye", and/or sensitivity to light. We want to know how bad your eye symptoms are and how they affect your daily life and the things you want to do like reading, driving, working with a computer, watching TV, or doing things you enjoy.

Please circle the number (1-10) that best describes your dry eye symptoms and how they affect your daily life over the past week.

On a scale of 1-10 how badly do your dry eye symptoms affect your daily life? ☺ 1 2 3 4 5 6 7 8 9 10 ☹

List medications you are currently taking, including eye drops. List your allergies to medications or other substances.

MEDICATIONS	ALLERGIES	VITAMINS SUPPLEMENTS

Dr David W Stemley & Associates
2540 El Camino Real Ste B
Carlsbad, CA. 92008

Notice of Privacy Practices

Patient Acknowledgement

Patient Name: _____

Date of Birth: _____

I have received and understand this practice's Notice of Privacy Practices written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information residing at, or controlled by, this practice. If changes to the policy occur, this practice will provide me a revised Notice of Privacy Practices upon my request.

Signature: _____

Date: _____

Relationship to patient (If signed by a personal representative of the patient):

_____

TOTAL VISION LIFESTYLE AND EYEWEAR EVALUATION

Patient: _____

CURRENT EYEWEAR

What types of eyewear do you currently own/wear?
Please check all that apply

- ❑ Single Vision (Distance)
- ❑ Bifocals (With-Line)
- ❑ Prescription Sunglasses
- ❑ Readers (Near)
- ❑ Progressive (No-Line)
- ❑ Non -Prescription Sunglasses
- ❑ Computer Designed Lenses

VISUAL ACTIVITIES

Favorite leisure activities/hobbies/sports: _____

Occupation: _____

I use a computer, tablet or smartphone ____ hours per day

I spend significant time outdoors ❑ Yes ❑ No

I generally drive ____ hours each day and ____ hours each night

EYEWEAR PERFORMANCE

Eyewear should provide you with comfortable vision throughout the day, during all of your activities.
Please check if you experience any of the following while wearing your current eyewear.

REFLECTIONS / GLARE FROM:

- ❑ Lights while driving at night
- ❑ Indoor Lighting
- ❑ Computer or digital device screens

DIFFICULTY FOCUSING:

- ❑ Distant Objects
- ❑ Arm's Length Objects
- ❑ Near Objects

OTHER

- ❑ Sensitivity to light

LASER VISION CORRECTION

Are you interested in LASIK? ❑ Yes ❑ No

CONTACTS

Do you wear contacts?

❑ Yes ❑ No

Are you happy with the comfort?

❑ Yes ❑ No

Are you happy with the vision?

❑ Yes ❑ No

What do you like about your current eyewear?

_____

_____

*Is there **anything** about the performance of your current eyewear or contact lenses you don't like or would change?*

_____

_____

_____