Visual Edge LLC

Welcome to our office!

Name____ Date of Birth_______________________

Address____ City______________________ Zip__________

Phone ________________________________ Email_________ _______________________________

Occupation/Student ________________________Employer/School______________________________

Hobbies / Recreational Activities ____

Main Reason for Today's Exam____

Any vision related concerns / needs?____

Date of Last Eye Exam___________________________ Were eyes dilated? Yes No

In the past have you had (please Check)

____ glasses ____soft contacts ____ rigid gas perm contacts ____ vision correction surgery ____ none

Today's exam is for (please check)

____ glasses ____soft contacts ____color contacts ____rigid (RGP) contacts ____Lasik consult

Please indicate all that pertain to your eyes (X) or to an immediate family member's eyes (F):

____surgery ____retinal detachment ____eye turn ____color blindness
____cataracts ____macular degeneration ____lazy eye ____flashes / floaters
____glaucoma ____injury / head trauma ____herpes ____double vision

Do you regularly use a computer? Yes / No If Yes :________hours per day For: Business / Leisure

During or after computer use do you notice any of the following?

____eye fatigue ____dry/burning feeling ____red eyes ____blurred vision ____headaches

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Have you ever been diagnosed or treated for:

____High Blood Pressure ____Arthritis ____Allergies ____Heart Attack ____Diabetes ____Stroke
____High Cholesterol ____Hepatitis ____Asthma ____Blood Disorder ____Medication Allergies
____Headaches / Migraines ____Depression / Anxiety ____Multiple Sclerosis Other ______________________

Are you currently ___Pregnant? ___A Smoker? Other__________________________________

Current Medications____

Over the Counter Eyedrops (Allergy etc.) ____

Whom may we thank for referring you?____

In order to provide a thorough exam, dilating eye drops may need to be used.
These eye drops may cause light sensitivity and blurred vision.

_____I give my permission for eye drops to be used *(or)* _____ I understand the reason for drops but refuse them today

Retinal photography is available for an additional fee ($25).
A digital image of your retina allows us to better monitor your ocular health.

_____I choose to have retinal photos taken *(or)* _____ I decline retinal photography today

I acknowledge receipt of Visual Edge LLC's Notice of Privacy Policies.

Eye exam charges are due in full at time of service, and are non-refundable. Visual Edge, LLC will be happy to assist you in paperwork for reimbursement from your insurance company. **We do not bill insurance companies directly.**

Please Sign: Patient or Guardian ____Date______________