Vision Source™

DR. JOSEPH S. DIGIORGIO
& ASSOCIATES

Orland Atrium Building
9031 W. 151St. Street
Orland Park
708 460-2010

Welcome to Our Office

(PLEASE PRINT)

Name ____

Address ____

City ______________________ State _______ Zip __________

Home Phone (_________) _________________________

Cell Phone (_________) _________________________

E-mail ____

Occupation (or Grade) ___________________________________

Today's Date _______________ Date of Last Exam ____________

Date of Birth _______________________ Age _______________

Sex: M____ F____ Social Security # _________________________

Spouse's (or Parent's) Name ______________________________

Medical Insurance ____________________________________

VIsion Insurance _____________________________________

Please Give Both Your Vision & Medical Insurance Cards to the Receptionist

How did you first hear about **VISION***Source* ?

❒ Referred by a **friend or a relative**

If so, **who may we thank**? ______________________

❒ Referred by another **doctor or teacher**

If so, who? ___________________________________

❒ **Website** / **Google** / **Yelp** / **Facebook** / _____________

❒ **Office Sign**

What is the **Main Purpose** of this visit?

What do you like about your present **Contact Lenses** or **Eyeglasses**?

____

Any problems with your present **Contact Lenses** or **Eyeglasses**?

____

Are you planning to **Update your Eyeglasses today?**

____

DO YOU HAVE ANY OF THE FOLLOWING WITH YOUR EYES?

- Blurry distance vision ....Yes / No
- Blurry near vision ....Yes / No
- Difficulty Working up close ......Yes / No
- Eye strain / tired eyes.............Yes / No
- Sensitivity to light ....Yes / No
- Glare or reflections..................Yes / No
- Difficulty Seeing at night..........Yes / No
- Double vision ....Yes / No
- Loss of side vision...................Yes / No
- Flashes / Floaters in vision......Yes / No
- Sudden loss of vision ....Yes / No
- Redness..................................Yes / No
- Gritty or sandy feeling ....Yes / No
- Dryness, Burning or Itching .....Yes / No
- Watery or Tearing eyes...........Yes / No
- Mucous discharge...................Yes / No
- Uncomfortable contacts...........Yes / No

Other___________________

LIST ALL CURRENT MEDICATIONS (Rx or Over the Counter)

		Name of Medication
High Blood Pressure Meds.....	Yes / No	____________________
Diabetes Meds or injections ...	Yes / No	____________________
Oral Contraceptives	Yes / No	____________________
Eye Drops	Yes / No	____________________
Other Medicines.....................	Yes / No	____________________
Under a physicians care?.......	Yes / No	Name: ______________

Please circle any family history for the following eye conditions

		Relationship to patient
Blindness	Yes / No	____________________
Cataracts................	Yes / No	____________________
Glaucoma...............	Yes / No	____________________
Macular Degen.	Yes / No	____________________
Retinal Detach........	Yes / No	____________________
Lazy Eye.	Yes / No	____________________
Other......................	Yes / No	____________________

Have you ever worn or are you currently wearing contact lenses?.................Yes / No

What kind?_____________ Solutions used_________________

Are you interested in contact lenses? ....Yes / No

❋ *This information is kept strictly confidential. You may discuss this portion directly with the doctor if you prefer.* ❋

- Do you use Tobacco products ....Yes / No If yes, type / amount / how long: ______________________________
- Do you drink alcohol ....Yes / No If yes, type / amount / how long: ______________________________

Have you ever been exposed to or infected with: ❒ Gonorrhea, ❒ Hepatitis, ❒ HIV, ❒ Syphilis

Review of Medical Systems:

- Do you have any allergies to medications?...........Yes / No If yes, please explain________________________________
- Are you pregnant and /or nursing?........................Yes / No

Vascular / Cardiovascular

- Diabetes ....Yes / No
- Heart Disease..Yes / No
- High Blood Pressure ....Yes / No
- Vascular Disease...Yes / No

Allergic/Immunologic.......................................Yes / No

Skin Conditions...Yes / No

Endocrine

- Thyroid / other glands ....Yes / No

Psychiatric Condition ....Yes / No

Ears, Nose, Mouth, Throat

- Allergies / Hay fever....................................Yes / No
- Sinus congestion ....Yes / No
- Runny Nose...Yes / No
- Post-nasal drip...Yes / No
- Chronic cough..Yes / No
- Dry throat/mouth ....Yes / No

Respiratory

- Asthma .... Yes / No
- Chronic Bronchitis.. Yes / No
- Emphysema... Yes / No

Neurological

- Headaches... Yes / No
- Migraine History .... Yes / No
- Seizures.. Yes / No

Gastrointestinal

- Diarrhea.. Yes / No
- Constipation... Yes / No

Genitourinary

- Genitals/kidneys / bladder .... Yes / No

Bones / Joints / Muscles

- Rheumatoid Arthritis.. Yes / No
- Muscle pain.. Yes / No

Lymphatic / Hematological

- Anemia .... Yes / No
- Bleeding problems .... Yes / No

Constitutional

- Fever, Weight loss/gain.................................. Yes / No

Circle any hobbies, Sports or special interests you engage in:

- Baseball
- Basketball
- Football
- Hockey
- Boating
- Fishing
- Skiing
- Soccer
- Golf
- Tennis
- Musical instruments
- Sewing or needlework
- Home workshop
- Card playing
- Biking
- Scrap Booking

Other:________________________________

Do You . . .

- spend more than **30 minutes per day on computer**? ....Yes / No
- **wear bifocals?** If so, are you bothered by head tilting, or restricted areas of vision correction?....................................Yes / No
- have **more than one pair** of current prescription glasses?........Yes / No
- have interest in **thinner, lighter lenses**? ....Yes / No
- have times you would rather **not wear glasses**? ....Yes / No
- have interest in **newer contact lens technology**? ....Yes / No
- want a **non-surgical option** to LASIK eye surgery? ....Yes / No
- spend more than an hour per day **outdoors or driving**? ....Yes / No
- have **U.V. protecting** prescription sunglasses? ....Yes / No
- have problems with **glare or night driving**? ....Yes / No

Payment Policy & Receipt of "Notice of Privacy Practices":

Please note that Well Vision exams are billable to <u>Vision Plans</u>. Patients requiring a physicians eye report or for those with medical history, diagnosis or medical conditions, such as Diabetes, Cataracts, or eye infections (just to name a few) that can affect the eyes are billable to <u>Medical Insurance Plans</u>.

Payment is required at the time of service. Most insurance policies pay only a portion of your total charges. If you have questions about your coverage, ***please contact your representative***. All insurance referrals need to be given to us ***<u>before</u>*** services. We ***<u>do not</u>*** guarantee the accuracy of benefit information given to us by insurance companies**!**

Please understand that financial responsibility is yours, not your insurance company's.

How will you settle your account today? ❒ Check ❒ Cash ❒ Credit

I personally guarantee payment and any necessary collection fees to collect payment of materials and/or services rendered. I authorize the release of any medical or other information necessary to process my care and acknowledge that I have reviewed this offices ***"Notice of Privacy Practices".***

Patient / Guardian Signature ____ *Thank You*