Vision Source!®

New Patient Registration Form

Keith Caudelle, O.D. *Michael E. Wilson, O.D., P.C.*

Patient's Name: _____
FIRST MIDDLE LAST

Parent or Guardian: _____

Street Address: _____

Zip Code: _____ City: _____ State: _____

Home Phone: ( ) _____ – _____ Ext. _____

Work Phone: ( ) _____ – _____ Ext. _____

Cell: _____ ☐ Self ☐ Mother/Father ☐ Other _____

Email: _____

Salutation: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. ☐ Rev. ☐ Other _____

Patient's Birthdate: ____/____/____ Legal First Name: _____

Sex: _____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Patient's Social Security Number: _____

Employer/School: _____ Occupation: _____

Employment: ☐ Full Time ☐ Part Time ☐ Retired ☐ Disabled ☐ Unemployed

Student: ☐ Full Time ☐ Part Time

Referred by: _____

Person responsible for payment: _____

It is customary to pay for professional services at the time they are rendered. When materials (glasses or contacts) are ordered, at least half of the total fee is expected at that time, and the balance is due when they are dispensed. **If you have vision insurance, all co-pays or deductibles and overages (on glasses or contacts) are due at the time of exam and order date. This is by instruction of your insurance company.**

Our office accepts Cash, Checks, MasterCard, Visa, and Discover cards.

The above information is accurate: _____
Signature *Date*

Please sign if correct.

SEE BACK SIDE!

Your Eye Health History

PLEASE CHECK ITEMS THAT APPLY TO YOU

Wear Glasses ..... ☐
Wear Contact Lenses– ..... ☐
RIGID OR SOFT(Circle One)
Previous Eye Injury ..... ☐
Eye Surgery..... ☐
Color Vision Deficiency ..... ☐
Amblyopia..... ☐
(LAZY EYE)
Macular Degeneration ..... ☐
Cataract..... ☐
Glaucoma ..... ☐
Floaters or Light Flashes..... ☐
Other Previous Diagnosed Conditions: ☐

Age vision first corrected:_____

Currently corrected: ☐ Full Time ☐ Reading Only ☐ Distance Only

When was your last exam?_____ Doctor seen: _____

Eye drops regularly used:

Are you considering: Contact Lenses:_____ Refractive Surgery:_____

Do you use a computer? ☐ Yes ☐ No Do you experience any eyestrain, headache or blurred vision after working on computers? ☐ Yes ☐ No

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Your Personal Medical History

CHECK ANY CONDITIONS YOU HAVE OR HAVE HAD

Arthritis..... ☐
High Blood Pressure..... ☐
Heart Disease..... ☐
Thyroid Disorder..... ☐
High Cholesterol ..... ☐
Asthma..... ☐
Diabetes ..... ☐
Migraine Headaches ..... ☐
Cancer ..... ☐
Hearing Loss ..... ☐
Prior Head Injury ..... ☐
HIV..... ☐
Use Tobacco Products ☐ Yes ☐ No
Treatment for Drug or Alcohol Abuse? ☐ Yes ☐ No

Other condition not listed:_____

Your present physician: Dr._____ Last physical: _____

Medications currently used: _____

Allergic to: Medications: _____ Seasonal Pollens _____

Your Immediate Family History

(PARENTS, SISTERS, BROTHERS, GRANDPARENTS)

Glaucoma..... ☐
Cataracts ..... ☐
Blindness..... ☐
Retinal Detachment ..... ☐
Macular Degeneration..... ☐
Color Vision Deficiency..... ☐
Amblyopia (LAZY EYE) ..... ☐
Crossed Eyes..... ☐
Diabetes ..... ☐
High Blood Pressure..... ☐
Heart Disease..... ☐
Stroke..... ☐

Thank You