



Welcome to Our Office!

Our goal is to provide the highest quality eye care and service. Our experienced staff and doctors are committed to excellence in meeting each patient's unique visual and eye health needs with the highest ethics and integrity.

Please Print general information

NAME Last First

TODAY'S DATE DATE OF BIRTH AGE Male Female

HOW WOULD YOU LIKE TO BE ADDRESSED

HOME ADDRESS

CITY STATE ZIP

PHONE Home Work Cell

EMAIL *how do you prefer to be contacted?* Email Phone

SOCIAL SECURITY NUMBER SPOUSE/PARENT

HOW DID YOU HEAR ABOUT US

PURPOSE OF TODAY'S VISIT

ARE YOU EXPERIENCING PROBLEMS WITH YOUR GLASSES OR CONTACT LENSES Yes No

If YES, please explain

Please Print occupation

EMPLOYER or SCHOOL

OCCUPATION or GRADE

Please Print visual needs

CHECK ALL THAT APPLY

- Work at a computer
- Have only one pair of glasses
- Want information on thinner, lighter lenses
- Wear bifocals
- Want information on lineless bifocals
- Prefer not to wear your glasses at times
- Interested in LASIK vision correction surgery
- Interested in a non-surgical approach to vision correction
- Problems with glare or reflections (even night driving)

- Work requires safety glasses
- Participate in sport activities What:.....
- Interested in the latest contact lens technology
- Hobbies? What kind:.....

DO YOU EXPERIENCE

- Uncomfortable glasses
- Glare or Reflections
- Sensitivity to Sunlight
- Trouble Seeing at Night

I acknowledge that I received a copy of Drs. Vogl and Lee Notice of Privacy Practices

Signature Date

eye care for a great life

15525 W. Roosevelt, Suite 108 • Goodyear, AZ 85338 • O: 623.925.2121 • F: 623.925.9605
10750 W. McDowell, Bldg. A, #100 • Avondale, AZ 85392 • O: 623.877.3007 • F: 623.877.4488

info@visionwellnesscenter.com • www.visionwellnesscenter.com



Insurance and Vision Benefits

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Please Print insurance

NAME First PROVIDER Lilien Vogl, O.D., F.A.A.O.
Adam J. Lee, O.D., F.A.A.O.

I request that payment under my insurance program be made to the provider named above on any bills for services furnished to me during the effective period of this authorization and I authorize the above named provider to release to the Insurance Company, or its intermediaries or carriers any information needed for this claim or any related claim. I further permit a copy of this authorization to be used in place of the original.

VISION PLAN Insurance Provider (example: VSP, EyeMed, Avesis)
PRIMARY'S NAME DOB / /
PRIMARY'S SSN - - PRIMARY'S ID #
Relationship to Insured

MEDICAL INSURANCE Provider (example: BCBS, Cigna, Aetna)
PRIMARY'S NAME DOB / /
PRIMARY'S SSN - - PRIMARY'S ID #
Relationship to Insured

SECONDARY INSURANCE Provider (example: BCBS, Cigna, Aetna)
PRIMARY'S NAME DOB / /
PRIMARY'S SSN - - PRIMARY'S ID #
Relationship to Insured

I authorize payment of medical benefits to the optometrist or supplier for services rendered.
The Insurance Company will only pay for services that it determines to be "reasonable and necessary". If the Insurance company determines that a particular service, although it would otherwise be covered, is "not reasonable and necessary"; they will deny payment for that service. If the Insurance Company denies payment, I agree to be personally and fully responsible for payment.

Signature Date

Please Print emergency contact

EMERGENCY CONTACT
Name Phone
Relationship to you

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Medical History

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Please Print general information

NAME Last First TODAY'S DATE
NAME OF PREVIOUS EYE DOCTOR LAST EYE EXAM
NAME OF MEDICAL DOCTOR LAST MEDICAL EXAM

Please Print history

DO YOU HAVE ANY ALLERGIES TO MEDICATIONS Yes No

If YES, please list

LIST ANY MEDICATIONS YOU TAKE *including oral contraceptives, aspirin, over the counter medications and home remedies*

.....
.....

LIST ANY MAJOR INJURIES, SURGERIES AND/OR HOSPITALIZATIONS

.....

CHECK ANY YOU HAVE HAD Glaucoma Retinal disease
 Crossed eyes Cataracts
 Lazy eyes Eye infections
 Drooping eyelid Eye injuries
 Prominent eyes
Do you wear glasses? Yes No
If yes, how old are your present glasses?
Do you wear contact lenses? Yes No
If yes, how old are your present lenses?
Type of lenses oxygen permeable extended wear
 soft other Comfortable? Yes No
Are you pregnant and/or nursing? Yes No

Please Print social history

This information is kept strictly confidential. However, you may discuss this portion directly with doctor.

I WOULD PREFER TO DISCUSS THIS INFORMATION DIRECTLY WITH MY DOCTOR Yes No

DO YOU DRIVE Yes No

If YES, do you have visual difficulty when driving Yes No If YES, please describe

.....

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

DO YOU USE ILLEGAL DRUGS Yes No If YES, type/amount/how long

HAVE YOU EVER BEEN EXPOSED TO OR INFECTED WITH Gonorrhea Hepatitis HIV Syphilis

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Medical History continued

Please Print

family history

PLEASE NOTE ANY FAMILY HISTORY

parents, grandparents, siblings, children; living or deceased

DISEASE/CONDITION	NO	YES	RELATIONSHIP TO YOU
Blindness			
Cataract			
Crossed Eyes			
Glaucoma			
Macular Degeneration			
Retinal Detachment/Disease			
Arthritis			
Cancer			
Diabetes			
Heart Disease			
High Blood Pressure			
Kidney Disease			
Lupus			
Thyroid Disease			
Other:			

Please Print

Do you NOW, or have you had problems in the following areas:

review of systems

SYSTEM	YES	NO	?	SYSTEM	YES	NO	?	SYSTEM	YES	NO	?
ALLERGIES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	EYES			
CARDIOVASCULAR				Dry Throat/Mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HEMATOLOGIC/LYMPHATIC				Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Distorted Vision/Halos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CONSTITUTIONAL				IMMUNOLOGIC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	INTEGUMENTARY (skin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weight Loss/Gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	MUSCLES/BONES/JOINTS				Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ENDOCRINE				Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sandy or Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid/Other glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GASTROINTESTINAL				NEUROLOGICAL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excess Tearing/Watering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GENITOURINARY				Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Glare/Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Genitals/Kidney/Bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	PSYCHIATRIC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eye Pain or Soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
EAR, NOSE, MOUTH, THROAT				RESPIRATORY				Chronic infection Eye/Lid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Styes or Chalazion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Flashes/Floaters oin Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Post-Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you answered YES to any of the above or have a condition not listed, please explain and list medications:

Doctor's Signature Date



Informed Consent for Photos – Digital Retinal Screening

Patient's Name _____

Vision Wellness, committed to providing the best patient care possible, is offering high resolution Digital Retinal Screening. This computerized technology aids us by establishing baseline images of the inside of your eyes. We can then compare this image with future images and carefully observe any normal or abnormal changes. We believe this will promote earlier diagnosis of many abnormal vision conditions such as, glaucoma, diabetic retinopathy, macular degeneration, retinal detachments, and other vision threatening conditions, which can result in permanent vision loss if not caught and treated in a timely manner.

We strongly encourage all of our patients receive these medical tests yearly or as recommended by your doctor. It is especially important for patients who have:

- **Headaches**
- **Spots or flashes of light**
- **Circulatory problems**
- **Eye Pain**
- **History of high blood pressure**
- **History of diabetes**
- **Family history of eye disease**
- **Strong eyeglass prescription**

The doctors at Vision Wellness strongly recommend the Digital Retinal Screening Exam. The fee for Digital Retinal Screening is **\$23** when performed and paid in full on the day of the examination. The fee is **\$72** when scheduled as a separate procedure on a different day. Please check the appropriate line below and sign at the bottom.

_____ **I DO** wish to have screening digital images taken of the back of my eye today. I understand there is a **\$23** charge, which is not covered by insurance or vision plan.

_____ **I DO NOT** request the above tests today. I understand the doctor's recommendations but wish to decline at this time.

Patient Signature _____ Date _____

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