

Welcome to the Vision Source Office of Joseph J. Raffa, O.D.

Thank-you, we appreciate your trust in our practice.

Name: \_\_\_\_\_ Email \_\_\_\_\_

Phone# (H) \_\_\_\_\_ (W/C) \_\_\_\_\_

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_ SS# \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_ Zip \_\_\_\_\_

Gender: M F Marital Status M S D

Medical Insurance: \_\_\_\_\_ Vision Insurance: \_\_\_\_\_

Primary insurance holder ID #(s) \_\_\_\_\_ Primary  
DOB \_\_\_\_\_

Employer (or School): \_\_\_\_\_

Occupation (or Grade): \_\_\_\_\_ Parent/Guardian \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Have you referred some one to our office? Who \_\_\_\_\_

**PLEASE CIRCLE PERSONAL MEDICAL HISTORY**

Allergies	Y N	Arthritis	Y N	Asthma	Y N
Cancer	Y N	Cataracts	Y N	Eye Injury	Y N
Eye Surgery	Y N	Glaucoma	Y N	Heart Disease	Y N
HBP	Y N	Kidney Issues	Y N	Nerves	Y N
Thyroid Disease	Y N				
Other	_____				

**CURRENT MEDICATIONS (Rx or over the counter)**  
Medication Name

Antihistamines \_\_\_\_\_

Blood Pressure Pills \_\_\_\_\_

Diuretic (water pill) \_\_\_\_\_

Oral Contraceptives \_\_\_\_\_

Sleeping Tablets \_\_\_\_\_

Eye Drops \_\_\_\_\_

Supplements / Others \_\_\_\_\_

Allergies to Medicines \_\_\_\_\_

Date of Last Eye Exam \_\_\_\_\_

Name of Last Eye Doctor \_\_\_\_\_

Date of Last Physical Exam \_\_\_\_\_

Name of Physician \_\_\_\_\_

**FAMILY MEDICAL HISTORY**

Relationship to you

Cataracts \_\_\_\_\_

Macular Degeneration \_\_\_\_\_

Blindness \_\_\_\_\_

Glaucoma \_\_\_\_\_

Diabetes \_\_\_\_\_

High Cholesterol \_\_\_\_\_

High Blood Pressure \_\_\_\_\_

Other \_\_\_\_\_

**Review of Systems**

Do you currently or have you ever had any problems in the following areas:  
(If yes, please explain and list medications below)

Ear,Nose,Mouth & Throat	yes no	Vascular	yes no
Gastrointestinal	yes no	Respiratory	yes no
Genitourinary	yes no	Lymphatic	yes no
Bone/Joints/Muscles	yes no	Hematological	yes no
Endocrine	yes no	Psychiatric	yes no
Skin	yes no	Neurological	yes no

**DESCRIBE THE MAJOR PURPOSE OF THIS VISIT.**

**Are you interested in new glasses today? Yes No If Needed**  
**Interested in new contact lenses today? Yes No If Needed**

**Do you experience..... (Please circle)**

BURNING	Y N	UNCOMFORTABLE GLASSES	Y N
ITCHING	Y N	FLASHES OF LIGHT	Y N
NAUSEA	Y N	LIGHT SENSITIVE	Y N
WATERY EYES	Y N	FAINING/ DIZZINESS	Y N
REDNESS	Y N	BLURRY DISTANCE VISION	Y N
DRYNESS	Y N	BLURRY NEAR VISION	Y N
SORENESS	Y N	GRITTY FEELING	Y N
GLARE	Y N	TROUBLE SEEING AT NIGHT	Y N
EYE STRAIN	Y N	DOUBLE VISION	Y
		N	
HEADACHES	Y N	SUDDEN LOSS OF VISION	Y N
OTHER	_____		

**VISUAL NEEDS**

**Do You..... (Please check)**

Work at a computer for long periods of time?

Have only one pair of glasses?

Only wear contacts do not have a back up pair of glasses.

Want information on DRY EYE treatments or products

Spend a lot of time outdoors?

Ever find a need for prescription sunglasses?

Have problems with glare or reflections (ex: night driving)?

Participate in sports? List \_\_\_\_\_

Want more information about Laser Vision Correction?

Want information about Sports Vision Training?

Want information about Vision Therapy?

We are more than happy to assist you in the filling of your insurance claims. If your insurance will not pay the anticipated amount we will bill you for the balance. Any insurance balance left unpaid is the patient's responsibility. A monthly rebilling fee of \$5.00 is added for accounts over 30 days. If an account requires services by a collection agency or attorney, patient will be responsible for fees. Returned check fee is \$25.00. WE REQUIRE A 48 HOUR NOTICE FOR APPOINTMENT CANCELLATIONS. A \$25 FEE MAY BE ASSESSED. Payment is due at the time of service unless prior written arrangements have been made.

I acknowledge that I have reviewed Dr. Raffa's insurance policies and Notice of Privacy Practices.

Signature \_\_\_\_\_

Date \_\_\_\_\_