Wildwood Vision Specialists

Kimberly Folwarski Brown O.D.
Christine Hayes O.D.

Welcome!

Thank you for choosing Wildwood Vision Specialists for your eyecare!
The following information will help our staff and your doctor provide you with the most complete care possible. We appreciate you taking the time to complete this to the best of your ability. If you have any questions please let us know and we would be happy to assist you.

Patient information:

Date: _____ Date of birth: _____

Legal Name: _____ Preferred/Nick name: _____

Preferred prefix: Dr. / Mr. / Mrs. / Ms. / Miss Sex assigned at birth: Male / Female / Other / Decline to answer

Address: _____ Marital status: Single / Married / Divorced / Widowed

City: _____ State: _____ Zip: _____ Employer/School: _____

Home or Cell phone: _____ Occupation/Grade: _____

Email address: _____ Preferred language: _____ Race: _____

Ethnicity: Hispanic/Latino OR Nonhispanic/Latino Communication preference: Phone / Text / Email / Mail

Preferred pronouns: (circle ALL that apply):

- she/her/hers
- he/him/his
- they/them/theirs
- others: _____

Current gender identity (circle ALL that apply):

- Male / Female
- Transgender male / Transgender female
- Gender queer
- Additional category (please specify): _____

Responsible party information: *If the answer to the first question is "self" you can skip to the next section*

Relationship to responsible party/guarantor: Self / Spouse / Child / Grandparent / Aunt / Uncle / Other

Name of guarantor: _____ Date of birth of guarantor: _____

Phone number of guarantor: _____

Address (if different from above): _____City: _____ State: _____ Zip: _____

Payment/Insurance information:

Medical insurance:

Primary insurance name: _____

Insurance ID#: _____

Subscriber name: _____

Secondary insurance name: _____

Insurance ID#: _____

Subscriber name: _____

Vision Insurance:

Primary vision insurance name: _____

Insurance ID#: _____

Subscriber name: _____

Secondary vision insurance: _____

Insurance ID#: _____

Subscriber name: _____

I certify that the information given by me about my insurance plan(s) is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and I authorize payment of these benefits directly to Wildwood Vision Specialists on my behalf for any services and materials furnished. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents as any information needed to determine these benefits payable to related services. If I have other health insurance coverage (as indicated in item 9 of the CMS-1500 form or electronically submitted claim) my signature authorize release of the above medical information to the insurer or agency shown, and authorizes my doctor to act as my agent as above.

Patient/guarantor signature: _____ Date: _____

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Eye / Vision concerns: Date of last exam: _____ Doctor's name: _____

Reason for today's visit (check all that apply):

- ☐ Annual check up, no current problems
- ☐ Trouble seeing clearly (driving, computer, reading)
- ☐ Need/want new glasses
- ☐ Need/want more contact lenses
- ☐ Would like to try contact lenses
- ☐ Interested in LASIK surgery
- ☐ Emergency eye problem (trauma/pain/vision loss)
- ☐ Eye discomfort: Itching / dryness / irritation / burning
- ☐ Floaters in vision
- ☐ Flashes of light in vision
- ☐ Loss of vision

Do you wear glasses? ☐ No ☐ Yes If yes: ☐ All the time ☐ Occasionally

Do you wear contact lenses? ☐ No ☐ Yes What brand are you currently wearing? _____

How happy are you with your current contact lenses? (use a scale of 1-10: 1=poor & 10=amazing)

Comfort: _____ Vision: _____

Any other symptoms/problems you'd like your doctor to be aware of? _____

Any tasks, hobbies, or sports that you feel like your vision needs improvement with? _____

Social history:

Recreational drug use (current or former)? ☐ No ☐ Yes If yes type: _____ Date last used: _____

Tobacco use (current or former)? ☐ No ☐ Yes If yes: ☐ Cigarettes ☐ Pipe ☐ Vaping ☐ Chewing tobacco

Date last used: _____ If current: ☐ Daily ☐ Socially ☐ Occasionally

Alcohol consumption? ☐ No ☐ Yes If yes: ☐ Daily ☐ Socially ☐ Occasionally

Screen time:

Between computers, tablets and phones how many hours/day is spent on a digital device? _____

Hobbies, what do you like to do for fun? _____

Allergies and medications:

****If you have a list of these items let us know and we can make a copy****

Medications/Vitamins/Supplements:

Eye drops: _____

_____

Medications: _____

_____

_____

_____

Vitamins/supplements: _____

_____

_____

Allergies/sensitivities and reaction:

Drugs: _____

_____

_____

_____

Foods: _____

_____

Environmental/Cosmetic: _____

_____

_____

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General health history:

Date of your last physical: _____ PCP's name: _____

Please indicate if you or any blood relatives (parents, grandparents, children, or siblings) have had any of the following

	Yourself	Family member – relationship		Yourself	Family member - relationship
AIDS/HIV	☐	☐	_____	Heart condition	☐	☐	_____
Alzheimers	☐	☐	_____	Hepatitis	☐	☐	_____
Anemia	☐	☐	_____	(Type _____)			
Anxiety	☐	☐	_____	Herpes	☐	☐	_____
Arthritis	☐	☐	_____	High blood pressure	☐	☐	_____
(Type _____)				High cholesterol	☐	☐	_____
Asthma	☐	☐	_____	Kidney disease	☐	☐	_____
Blindness	☐	☐	_____	Lazy/turned eye	☐	☐	_____
Brain tumor	☐	☐	_____	Lupus	☐	☐	_____
Cancer	☐	☐	_____	Macular degeneration	☐	☐	_____
(Type _____)				Migraine headaches	☐	☐	_____
Cataracts	☐	☐	_____	Multiple sclerosis	☐	☐	_____
Colitis	☐	☐	_____	Myasthenia gravis	☐	☐	_____
Crohn's disease	☐	☐	_____	Pacemaker	☐	☐	_____
Depression	☐	☐	_____	Parkinsons	☐	☐	_____
Diabetes	☐	☐	_____	Retinal detachment	☐	☐	_____
(Type _____)				Sickle cell or trait	☐	☐	_____
Emphysema	☐	☐	_____	Shingles	☐	☐	_____
Epilepsy	☐	☐	_____	Skin disorder	☐	☐	_____
Eye surgery	☐	☐	_____	Stroke	☐	☐	_____
(Type _____)				STD	☐	☐	_____
Fibromyalgia	☐	☐	_____	(Type _____)			
Glaucoma	☐	☐	_____	Thyroid condition	☐	☐	_____
Graves disease	☐	☐	_____	Ulcers	☐	☐	_____
Hay fever	☐	☐	_____	Vision training	☐	☐	_____
Head injury	☐	☐	_____				

Other conditions: _____

History of major surgeries: _____

_____

Are you currently pregnant? ☐ No ☐ Yes

If yes what is your estimated due date?

_____

Are you currently breast feeding? ☐ No ☐ Yes

Thank you!