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ALL PATIENTS SHOULD BE PREPARED TO BE DILATED AT THE FIRST VISIT, UNLESS WE ARE EVALUATING CONTACT LENSES THAT DAY. PLEASE SEE DETAILS BELOW OR ON OUR WEBSITE.

To Our New Patient:

First, let me welcome you to this practice. We are delighted you have decided to join us. Our suite has been an optometry practice since 1964, when the first owner moved into this building. I am the third owner, having bought the practice in September 2005. The thrust of this practice has always been to provide very personalized, patient and thorough eye care and I am doing my best to continue and to expand upon this tradition. If you are tired of being treated as a number by doctors whose offices are like factories, then you have come to the right place.

Paperwork. Enclosed is the history form for you to fill out. Please bring it to your appointment. It helps me understand your entire medical situation, as the health of your eyes is so intimately connected to the health of the rest of your body. **If you are having vision problems at the computer, or eye discomfort at the computer, please measure the distance from your eyes to the computer screen, and the distance from your eyes to paperwork, and record these measurements on the form.**

Eyeglasses. **Please bring your glasses that give you the best vision.**

Contact Lenses. **If you wear contact lenses and are happy with the comfort or vision, please wear them to the appointment and bring any packaging or a written contact lens prescription.** If you wear contact lenses or if you would like to be fit into contact lenses, there will be an additional fee. The contact lens fee will depend on your situation. The fee is lower if your contact lenses work well, but it will be larger if we will be fitting you into a new lens. Feel free to ask the doctor at your appointment for an estimate of the contact lens fee. Sometimes we can use your vision plan for the contact lens fee. Patients sometimes ask why we charge a contact lens fee. The reason for this is that we must perform additional tests and spend more time with contact lens wearers (including possible follow-up visits) to assure that the lenses fit well, provide the best possible vision, and are not harmful to the eyes in any way. It is typical for most eye doctors to charge a contact lens fee for time spent evaluating patients' contact lenses.

Pupillary Dilation. We often consider it important to dilate our patients' pupils. This allows us to check the health of the structures inside of the eyes with more accuracy. Dilation affects different people differently. If we advise that dilation be performed, we will review with you how your vision is likely to be affected. Side effects may last from 3 to 6 hours. **You will notice light sensitivity and you may have distance blur, reading blur, or both.** We will provide disposable sunglasses if you don't have your own. Some patients can drive and function well after dilation but some cannot. If you are concerned about driving after being dilated, you may bring a driver to the exam. You may, of course, refuse the dilation. If you arrive late to the appointment, there may not be enough time to perform the dilation. **If we are examining contact lenses at your first visit, then we may postpone the dilation to another day.**

Location and Parking. We are in a nine-story white building on the north side of Colorado Blvd., across the street from Paseo Mall, between Euclid and Garfield. **Please use the three-story beige parking lot in back of our building. The parking lot address is 330 East Union.** We will validate your parking ticket and your parking will be free. **In general, it is best to park in the lot and not on the street, as sometimes exams run longer than expected, and we don't want you to get ticketed.**

I am looking forward to meeting you at your exam!

Sincerely,
Andrew Gore, O.D.

Name		Today's date		
Home Address		City	State	Zip
Birthdate	Age	<input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security No.	
Home phone	Work phone		Cell phone	
Occupation	Employer	Hobbies	Do you drive? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Please list <input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Spouse		Person Responsible for Billing if not patient		
Emergency contact – name and phone number		Who referred you to our office or how did you hear about us?		
If you have any family members who are Due for an eye exam, you may list them:		EMAIL ADDRESS (Helpful for recalls or if the doctor needs to contact you)		

MEDICATIONS (pills, eyedrops, vitamins, minerals, herbal supplements, injections)	MEDICINES YOU ARE ALLERGIC TO

THE PURPOSE OF YOUR VISIT TODAY IS (please describe as needed)

<input type="checkbox"/> Need new glasses	<input type="checkbox"/> Problem with glasses	<input type="checkbox"/> Need contact lenses	<input type="checkbox"/> Problem w/contact lenses
<input type="checkbox"/> Eye discomfort		<input type="checkbox"/> Seeing flashes	<input type="checkbox"/> Seeing floaters
<input type="checkbox"/> Hard to see streetsigns		<input type="checkbox"/> Double vision	<input type="checkbox"/> Glare <input type="checkbox"/> Light sensitivity
<input type="checkbox"/> Hard to read fine print		<input type="checkbox"/> You may describe these or other eye/vision problems or concerns you are having:	
<input type="checkbox"/> Problems at the computer. PLEASE MEASURE: distance from eyes to screen _____ distance from eyes to paperwork _____ hours/day at computer _____			

YOUR EYE HISTORY

Month/Year of last eye exam	Name of eye doctor and city		
If you have had any eye or head injury , when, which eye(s) and how did it occur?	List any eye surgeries and year performed		
Have you ever been told you have any eye disease or other eye condition ?			
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Macular degeneration		
<input type="checkbox"/> Corneal ulcer	<input type="checkbox"/> Strabismus/crossed eyes		
<input type="checkbox"/> Dry eyes	<input type="checkbox"/> Amblyopia (lazy eye)		
<input type="checkbox"/> Other:			
If you wear CONTACT LENSES , do you wear <input type="checkbox"/> soft <input type="checkbox"/> rigid gas permeable			
	Contact Lens Brand Name	Power	Base Curve
Right			
Left			

FAMILY EYE AND HEALTH HISTORY

Does a BLOOD RELATIVE have any of these diseases?	<input type="checkbox"/> Blindness Who?
<input type="checkbox"/> Glaucoma . Who?	<input type="checkbox"/> Diabetes . Who?
<input type="checkbox"/> Macular degeneration . Who?	<input type="checkbox"/> Other family eye diseases . Describe:
<input type="checkbox"/> Retinal detachment . Who?	

(THIS IS A 2-SIDED FORM. PLEASE TURN PAGE OVER.)

