Dr. Carlos Pessoa-Optometrist ***Welcome to Our Office!***

Our Mission: ***The Staff of Family Vision Development Center is dedicated to providing the highest quality of vision care in both services and products. We hope to inspire confidence through patient education, and to provide professional, friendly, and caring service at all times.***

Patient's Full Name: _____ Name Preferred to be called: _____
Mailing Address: _____ City, State, Zip: _____
Date of Birth: _____ Gender: ☐ M ☐ F Social Security Number: _____

Race:
☐ White ☐ African American
☐ American Indian ☐ Asian
☐ Latino ☐ Other: _____

Ethnicity:
☐ Hispanic
☐ Non Hispanic

Home Phone: _____ Cell: _____ Work Phone: _____
Email Address: _____ Height: _____ Weight: _____
Best Way to Contact: *OK to leave messages? * Text Ok?
☐ Home ☐ Cell ☐ Work ☐ Text ☐ Email ☐ Yes ☐ No ☐ Yes ☐ No
Patient's Employer/School: _____
Employer Address: _____ Occupation: _____
Work Status: Full Time Student?
☐ Full Time ☐ Part Time ☐ Retired ☐ Student ☐ Yes ☐ No

Spouse/Parent: _____ Spouse/Parent Employer: _____
Work Phone: _____ Spouse/Parent Social Security Number: _____
Spouse/Parent Date of Birth: _____
Emergency Contact Not Living With You: _____ Phone: _____
Whom May we Thank for referring you to us? _____

Vision Insurance: _____ Member's Name: _____
Member's Date of Birth: _____ Member # _____
Medical Insurance: _____ Member's Name: _____
Member's Date of Birth: _____ Member # _____

What is the Major Purpose of this visit? _____
Any problems with your present contact lenses or glasses? _____

Patient Medical History: (Check all that apply)
☐ Arthritis ☐ Diabetes ☐ Glaucoma
☐ Cancer ☐ Eye Injury ☐ High Blood Pressure
☐ Cataracts ☐ Eye Surgery ☐ Kidney Problems
Anything Else: _____

Family Medical History: (Check all that apply)
☐ Cancer ☐ Glaucoma ☐ High Cholesterol
☐ Diabetes ☐ High Blood Pressure ☐ Macular Degeneration
Anything Else: _____

Current Medications / Name of Medication: *If you have a medication list, we'll be happy to copy it for your record.*

_____

_____

_____

_____

Allergies to Medications: _____

Date of Last Eye Exam: _____ Name of Last Eye Doctor: _____

Name of Physician: _____ Date of Last Physical Exam: _____

Do You Experience (Check all that apply):

☐ Trouble Seeing at Night	☐ Double Vision	☐ Headaches	☐ Fainting or Dizziness
☐ Dryness	☐ Flashes of Light	☐ Redness	☐ Blurry Distance Vision
☐ Burning	☐ Soreness	☐ Uncomfortable Glasses	☐ Blurry Near vision
☐ Itchiness	☐ Glare or Reflection	☐ Sudden Loss of Vision	☐ Gritty Feeling in Eyes
☐ Nausea	☐ Eye Strain	☐ Sensitivity to Light	☐ Objects Floating in Vision
☐ Watery Eyes			

Anything Else: _____

Visual Needs: (Check all that apply)

☐ Work at a computer for long periods of time?

☐ Want information on thinner/lighter lenses?

☐ Prefer not to wear your glasses at times?

☐ Ever find a need for prescription sunglasses?

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

☐ Wear or ever tried wearing contact lenses? What kind? _____

☐ Participate in sport activities? What kind? _____

☐ Want more information about corrective vision surgery?

☐ Want more information about Corneal Refractive Therapy?

☐ Wear bifocals?

☐ Have only one pair of glasses?

☐ Want information on lineless bifocals?

☐ Do work requiring Safety glasses?

☐ Spend a lot of time outdoors

Social History: This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer. This information is important for medical purposes as well as compliance with insurance directives.

☐ Yes, I would prefer to discuss my social history information directly with my doctor

Do you use tobacco products? ☐ Yes ☐ No Do you drink alcohol? ☐ Yes ☐ No How Often? _____

Do you use other substances? ☐ Yes ☐ No Have you been exposed to sexually transmitted Diseases? ☐ Yes ☐ No

Review of Systems (Check all that apply)

Allergic / Immunologic	Eyes	Musculoskeletal	Cardiovascular
☐ Drug Allergy	☐ Glaucoma	☐ Fibromyalgia	☐ Heart Disease
☐ Environmental Allergy	☐ Cataracts	☐ Muscular Dystrophy	☐ Hypertension
☐ Rheumatoid Arthritis	☐ Macular Degeneration	☐ Osteoarthritis	☐ Stroke
☐ Lupus	☐ Surgery	☐ Ankylosing Spondylitis	☐ Vascular Disease
☐ None	☐ Inflammatory Disorders	☐ None	☐ None
	☐ Blurred Vision		
	☐ Double Vision		
	☐ None		

Gastrointestinal	Neurological	Constitutional	Genitourinary
☐ Crohns	☐ Multiple Sclerosis	☐ Developmental Disability	☐ STD/Viral Herpetic
☐ Colitis	☐ Epilepsy	☐ Weight Loss	☐ Chlamydia
☐ Ulcer	☐ Alzheimers	☐ Fever	☐ Kidney Ailments
☐ Digestive	☐ Parkinsons	☐ Fatigue	☐ None
☐ None	☐ Cerebrovascular	☐ Trauma	
	☐ None	☐ None	

Psychiatric	Ear, Nose, and Throat	Hematological / Lymphatic	Respiratory
☐ Depression	☐ Upper Respiratory Tract Infection	☐ Anemia	☐ Tobacco User
☐ Panic Disorder	☐ Ear Ache	☐ Large Volume Blood Loss	☐ Asthma
☐ Schizophrenia	☐ Runny Nose	☐ Leukemia	☐ Bronchitis
☐ None	☐ Sore Throat	☐ None	☐ Emphysema
	☐ Ringing/Tinitis		☐ None
	☐ None		

Endocrine	Integumentary	Other
☐ Diabetes/Non Insulin Dependent	☐ Eczema	_____
☐ Diabetes/Insulin Dependent	☐ Rosacea	_____
☐ Thyroid Dysfunction	☐ Psoriasis	_____
☐ Hormonal Dysfunction	☐ None	_____
☐ None		

I hereby authorize release of medical information to my insurance company and assign to Dr. Carlos E. Pessoa, all payments for services rendered to me or my dependents. This assignment will remain in effect until revoked by me in writing. A copy of this authorization may be used in place of the original. **Payment is expected at the time of the visit. Insurance will be filed only if Dr. Pessoa is a provider for my insurance plan; however, I must provide a current insurance card with a complete address for claims. It is my responsibility to obtain a referral should my insurance require specialist referrals. Should my insurance not pay the charges in a timely manner (maximum 90 days), I will be responsible for the entire balance. I am responsible for any charges denied by my insurance company for any reason.**

I agree to pay any and all collection charges should my account be turned over for collection procedures.

I further understand that my vision health examination does not include a contact lens prescription. The contact lens fitting is a separate procedure.

My payment will be: ☐ ***Cash*** ☐ ***Check*** ☐ ***Credit Card***

Patient Signature: _____ **Date:** _____

Parent/Guardian Signature: _____ **Date:** _____

*** Required for Patients Under Age 18 ***

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