



Steven C. Davenport, OD

Joy Rosner, OD

Robert A. Salchak, OD

Nikki Polnick, OD

Welcome to Our Office

Date: ___ / ___ / ___

Name: (Dr./Mr./Mrs./Ms.) _____, _____ (Last) (First) (MI)

Birth Date: ___/___/___ Social Security#: _____-____-_____

Responsible Party (if patient is a minor): _____

Street Address: _____ City: _____

State: _____ ZIP Code: _____ Email Address: _____

Phone: _____ Work: _____ Cell: _____

Occupation: _____ Employer: _____

Spouse's Name: _____ Spouse's Work Phone: _____

Hobbies: _____

Whom may we thank for referring you to us? _____

Insurance

Vision Insurance Company: _____

Name of Insured: _____ ID#: _____

Health Insurance Company: _____

Name of Insured: _____ ID#: _____

Group Number: _____ Insurance Company Phone: _____

Our payment policy requires that you pay in full at the service is rendered. Payment may be made by cash, check, Visa, MasterCard, Discover, or American Express.

Financial Agreement

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents, guardians, or personal representatives are responsible for all fees and services rendered for treatment of any minor/child. I accept full responsibility for all charges for service or items provided to me, to my minor/child, or to the patient for whom I have legal responsibility. I understand that filing a claim with my insurance company does not relieve me from my responsibility for the payment of all charges.

Signature: _____ Date: _____

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Medical History Questionnaire

Name: _____ Date: ____/____/____

Last Eye Exam: ____/____/____ Reason for seeking exam today: _____

Name of Medical Doctor: _____ Date of Last Physical: ____/____/____

List any medications you take and current conditions (Including oral contraceptives, aspirin, over the counter medications, eye drops, and nutritional supplements) _____

Are you allergic to any medications? _____

List all major surgeries, injuries, and/or hospitalizations you have had: _____

Do you wear glasses? No Yes How old are the lenses? _____
 Have you worn/wear contact lenses? No Yes How old are the lenses? _____
 Are you interested in contacts? No Yes
 Are you interested in Lasik? No Yes
 Are you interested in corneal refractive therapy as a non-surgical alternative to treat near-sightedness? No Yes
 Do you use prescription or non-prescription sunglasses? _____
 Have you had any eye surgeries or eye therapy? No Yes When? ____ Doctor: _____ Please describe: _____
 Family History: Please note any family history of systemic disease and/or specific eye diseases: _____

Please list any family members who have visited us before: _____

Do you currently, or have you ever had any problems in the following areas?

Neurological

Headaches No Yes
 Migraines No Yes
 Seizures No Yes

Cardiovascular

Diabetes No Yes
 Heart pain No Yes
 High blood pressure No Yes
 Vascular disease No Yes

Eyes

Loss of vision No Yes
 Blurred vision No Yes
 Distorted vision or halos No Yes
 Fluctuating vision No Yes
 Glare/Light Sensitivity No Yes
 Double vision No Yes
 Tired eyes No Yes
 Macular degeneration No Yes
 Eye injury No Yes

Social

Smoke/use tobacco No Yes
 Drink alcohol No Yes
 Use recreational drugs No Yes

Bones/Joints/Muscles

Rheumatoid arthritis No Yes
 Muscle pain No Yes
 Joint pain No Yes

Crossed eyes No Yes
 Lazy eye No Yes
 Drooping eyelid No Yes
 Prominent eyes No Yes
 Glaucoma No Yes
 Retinal disease No Yes
 Cataracts No Yes
 Eye infections No Yes

Please circle to indicate how often you experience the following with your eyes:

Mucous discharge	Never	Slight	Moderate	Severe
Redness	Never	Slight	Moderate	Severe
Burning	Never	Slight	Moderate	Severe
Gritty or sandy sensation	Never	Slight	Moderate	Severe
Pain or soreness	Never	Slight	Moderate	Severe
Tearing or watery eyes	Never	Slight	Moderate	Severe
Dryness	Never	Slight	Moderate	Severe