Optical effects Vision center
9895 S Maryland Parkway | Suite D | Las Vegas, NV 89183
P 702.435.3937 | F 702.436.3937 | www.OpticalEffectsLV.com
Robert M Wlodek, OD

Male ❑ Female ❑

Mr. Mrs. Miss Ms. Dr. Date of Birth _____ SSN _____

Last Name _____ First Name _____

Address _____ Home Phone _____

City _____ State _____ Zip _____ Work /Ext _____

E-mail address _____ Cell Phone _____
Please print clearly

Preferred method of contact Email ❑ Text ❑ Voicemail ❑

Employer/School _____ Occupation/Grade _____

If you are new to our office, please indicate how you found out about our practice _____

When was your last eye exam? _____ Who was the Doctor? _____

When was your last physical exam? _____ Who was theDoctor? _____

PRIMARY INSURANCE | Name of Policy Holder _____

Medical _____ Vision _____ SSN or Member ID _____ Primary DOB _____

SECONDARY INSURANCE | Name of Policy Holder _____

Medical _____ Vision _____ SSN or Member ID _____ Primary DOB _____

REASON FOR VISIT

No problems/Regular check-up ❑ I would like new glasses ❑ I would like contact lenses ❑
My distance vision is blurry ❑ My near vision is blurry ❑ Other _____

HEALTH INFORMATION

Since certain conditions are hereditary, it is important that we know you and your family's health history. Only denote blood relatives. **Me** (yourself), **M** (mother), **F** (father), **GM** (grandmother), **GF** (grandfather), **B** (brother), **S** (sister)

Multiple Sclerosis	High Cholesterol	Flashes	Redness
Cancer/Tumors	Arthritis	Floaters	Blurred Vision
High Blood Pressure	Thyroid	Lazy Eye	Visual Field Loss
Diabetes	Asthma/Bronchitis	Dry Eyes	Retinal Detachment
Kidney/Liver Problems	Stroke	Itching	Double Vision
HIV	Cataracts	Burning	Color Vision Loss
Hepatitis	Glaucoma	Tearing	Macular Degeneration
Other			
Explain any eye injury or surgery			

List all drugs/medications are you taking	Condition prescribed for

Drug allergies _____

Are you pregnant or nursing? **Y N** Do you smoke? **Y N**

Please continue on reverse side

VISUAL NEEDS ASSESSMENT

What is your primary form of visual correction?

Glasses ❑ Soft contact lenses ❑ Gas permeable contact lenses ❑ No correction ❑

When was your last change in glasses? _____

What are your current glasses? Single Vision ❑ Bifocals ❑ Trifocals ❑ Progressive (no line) ❑

Do you have prescription sunglasses? **Y N** Do you have spare glasses? **Y N**

Do you use a computer? **Y N** How much time on average do you spend on a computer daily? _____

CONTACT LENSES

Do you currently wear contact lenses? **Y N**

If No Have you ever worn contact lenses? **Y N** If yes, how long ago?_____ What type? Soft ❑ Rigid ❑

Would you want to wear contact lenses? **Y N**

Explain when you would rather not wear glasses:

_____

If Yes What type? Daily disposables ❑ Two-week disposables ❑ Monthly disposables ❑

Non-disposable soft lenses ❑ Rigid gas permeable ❑ Unknown ❑

Do you sleep in them? **Y N**

If Yes Rarely ❑ Once a week ❑ Few nights/week ❑ Regularly ❑ Naps ❑ Max daily hours_____

If No On average, how many hours a day do you wear contacts?_____

What contact solutions do you use?_____ What moisture drops do you use?_____

What would you like to improve about your contact lenses?

_____

ULTRA-WIDEFIELD RETINAL IMAGING

Optomap Ultra-widefield Retinal Exam is a revolutionary diagnostic tool that allows Dr. Wlodek to view a majority of the retina. The Optomap is a non-dilating camera that captures a digital image of the retina. Retinal imaging is the preferred method for Dr. Wlodek to monitor your eye health. Retinal imaging is recommended yearly. There is a $35 fee to perform this procedure.

It is the policy of Optical Effects Vision Center to require:

- All exam fees to be paid in full on the date of service
- Payment in full or a 50% deposit before an order can be placed
- Balance to be paid when the order is dispensed

We will do all we can to find out what your vision insurance benefits are and what you are eligible for. We will also submit your claim for you. The information given to us by your insurance company, however, is not a guarantee of payment from them.

All orders are final when placed.
I understand I am responsible for any charges not covered by my insurance company.
I acknowledge that I received a copy of Optical Effects Vision Center Notice of Privacy Practices.

Patient/Guardian Signature _____ Date _____
Signature required for insurance company billing

Thank you for choosing Optical Effects Vision Center for your eye care needs.

Please silence your cell phone