COLEMAN
Vision
IMPROVEMENT CENTER

WELCOME TO OUR OFFICE

Today's Date _____

Patient Information

Last _____
First _____MI _____
Street _____
City _____ State _____
Zip Code _____
Home Phone _____
Work Phone _____
Cell Phone _____ **Text?** _____
Patient's SSN _____
Employer (or School) _____
Occupation (or Grade) _____
Spouse (or Parent's Name) _____
Spouse (or Parent's Work) _____
Patient (child) resides with _____
Date of Birth _____Age _____
Sex M F
Email Address _____
What is the major purpose of this visit?

_____

Any problems with your current contact lenses or glasses?

_____

_____

VERY IMPORTANT! NEW PATIENTS ONLY:
Who may we thank for referring you to our office?
Name of friend or relative _____
❑ Share the Care referral ❑ Yes ❑ No
❑ Another Dr. _____
If not referred, how did you choose our office?
❑ Insurance List
❑ Saw Sign/Building
❑ Newspaper/Radio/TV: Which one? _____
❑ Yellow Pages: Which directory? _____
❑ Web Page: Which Web Site? _____
❑ BNI Member? _____
❑ Other _____

OUR VISION

At Coleman Vision Improvement Center we are called to a mission of improving the lives of the patients we serve through trusted, compassionate, innovative, and holistic vision and eye health care. For three generations, our Doctors and staff continue to uphold the highest standard of care, providing community wellness through education and uncompromised service.

We look forward to serving you!

Insurance Information

Please note that insurance does NOT cover the Contact Lens Follow-Up Evaluation.

Vision Insurance_____
Subscriber Name_____
Subscriber SSN_____
Subscriber Birth Date_____

Primary Medical Insurance_____
Subscriber Name_____
Subscriber SSN_____
Subscriber Birth Date_____

Do you participate in a flex spending account?
❑ Yes ❑ No
How will you settle your account today?
❑ Cash ❑ Check ❑ Credit Card

Lifestyle Questions

Do you……(check box if your answer is yes)
❑..work at a computer?
❑..think you might benefit from thinner, lighter lenses?
❑..have interest in a "test drive" of the latest contact lens designs
❑..spend time outdoors? How much? __Hrs/week
❑..have prescription sun wear?
❑..have problems with glare?
❑..play any sports? _____
❑..have any hobbies? _____
❑ Are you ❑right or ❑left handed?
❑..prefer not to wear your glasses at times?
❑..want information on Laser Vision Correction surgery?
❑..have interest in a Non-Surgical approach to vision correction?
❑..have more than 1 pair of current Rx eyewear?
❑..have children?
❑..have family members in need of eyecare?

Have you ever experienced, been diagnosed or treated for any of the following?

❑ Blurry Vision
❑ Cataracts
❑ Crossed eye/Eye turn
❑ Eye Infections
❑ Flash of light
❑ Glaucoma
❑ Headaches
❑ Itchiness
❑ Macular Degeneration
❑ Retinal Detachment
❑ Tearing
❑ Uncomfortable glasses
❑ Burning
❑ Corneal Abrasions
❑ Double Vision
❑ Eye Injury
❑ Floaters/Spots
❑ Grittiness
❑ Iritis/Uveitis
❑ Lazy Eye
❑ Occasional dryness
❑ Sunlight Sensitivity
❑ Trouble seeing at night
❑ Other eye disorders

The information in this confidential case history form is critical to the evaluation of your vision and health.

Patient Medical History

Name of Family Physician_____
Date of Last Physical Check-up_____

CURRENT MEDICATIONS (Rx or Over the Counter)
(List name of medications including eye drops, vitamins, & birth control pills)_____

_____

Allergies to medications? ❑ Yes ❑ No
If so, what medications?_____

_____

Are you currently pregnant? ❑ Yes ❑ No
Are you nursing? ❑ Yes ❑ No
Have you had any surgeries? ❑ Yes ❑ No
If so, please explain:_____

_____

Do you use cigarettes/tobacco, alcohol, or other substances? ❑ Yes ❑ No

Have you ever been diagnosed or treated for the following health problems?	**Yes**	**No**
Allergies	❑	❑
Arthritis	❑	❑
Blood/Lymph	❑	❑
Bronchitis/Asthma	❑	❑
Cancer	❑	❑
Cholesterol	❑	❑
Diabetes	❑	❑
Digestive	❑	❑
Ears/Nose/Throat	❑	❑
Endocrine	❑	❑
Eczema/Rashes	❑	❑
Fatigue	❑	❑
Fevers	❑	❑
Genitourinary	❑	❑
High Blood Pressure	❑	❑
Integumentary (Skin)	❑	❑
Kidney	❑	❑
Muscle/Bone	❑	❑
Neurological	❑	❑
Psychological	❑	❑
Respiratory	❑	❑
Sinus	❑	❑
Throat Infections	❑	❑
Thyroid	❑	❑
Unusual weight losses/gains	❑	❑

I acknowledge that I had available to me a copy of: Coleman Vision Improvement Center, David R. and Jeffrey D. Coleman, L.L.C. Notice of Privacy Practices. I, also, state that all the information given is true factual to the best of my ability.

Print Name: _____

Signature: _____

Patient Eye History

Date of Last Eye Exam_____
By Whom?_____

Are you planning on getting glasses today? ❑Yes ❑ No

Have you ever tried contact lenses? ❑ Yes ❑ No

Do you currently wear contact lenses? ❑ Yes ❑ No
What kind?_____
Solutions used_____

Are you satisfied with the vision and comfort of your contact lenses? ❑ Yes ❑ No

Would you prefer clear contact lenses or colored contact lenses? ❑ Clear ❑ Colored

If you wear bifocals, do the lines or head tilting bother you? ❑ Yes ❑ No

Family Medical/Eye History (Check all that apply)

Is there a family medical history of any of the following:
❑ No ❑ Yes (Please check boxes)

	Relationship (Mother's or Father's side)
Blindness	❑_____
Cataracts	❑_____
Corneal Problems	❑_____
Diabetes	❑_____
Glaucoma	❑_____
Heart Disease	❑_____
Lazy Eye	❑_____
Macular Degeneration	❑_____
Retinal Problems	❑_____

Date: _____

I, _____ (patient name) understand that I am seeing Dr. Coleman with:

☐ Verification of eligibility for services by VSP/EyeMed/Mercy/Davis Vision

☐ A required referral from my Primary Care Physician [referral form necessary]

☐ Verification of Medicaid

[Medicaid, MC+ or state funded Medical Assistance benefits are available to individuals who are determined eligible by the Division of Family Services. Each eligibility group or category of assistance has its own eligibility determination criteria that must be met in order for benefits to be paid.]

☐ Verification of Medicare

[I have read and understand the Medicare program for vision healthcare. I further understand that I am legally responsible for payment to Dr, Coleman for non-covered services deemed not medically necessary as well as any deductible and the patient's responsible portion of the Medicare allowable.]

☐ Other: _____

I understand that if my eligibility cannot be verified or if I do not obtain the proper referral form when required, I will be financially responsible for payments of all charges incurred for services received from CVIC.

I hereby authorize payment of my medical benefits to Dr. David Coleman or Dr. Jeff Coleman and authorize release of any information required to process any and all claims for reimbursement on my behalf.

Signature of patient: _____ Date: _____

Parent/Guardian signature (if minor): _____ Date: _____

RELEASE OF INFORMATION AUTHORIZATION

Please list any family members or friends that may call in or come by to ask questions or request information regarding your medical condition(s) or test(s) results below with your signed release.

I, _____, give permission to Dr. David Coleman and Dr. Jeffrey Coleman and his staff to reveal to the following person(s) any information concerning my medical condition(s) or result(s).

Name _____ Relationship_____ D.O.B_____

Name _____ Relationship_____ D.O.B_____

Name _____ Relationship_____ D.O.B_____

Name _____ Relationship_____ D.O.B_____

Name _____ Relationship_____ D.O.B_____

I understand this may include information to be released over the phone to the person(s) name above, therefore will be identified by their name and date of birth.

Signed _____ _____ Date_____

Relationship with Patient

Vision and Learning Assessment

Name _____

Date_____ Age_____

After you consider each question, mark the column that applies to the person you are assessing.

	NEVER	SELDOM	OCCASIONAL	FREQUENTLY	ALWAYS	SCORE
Blur when looking at near	0	1	2	3	4	
Double vision, doubled or overlapping words on page	0	1	2	3	4	
Headaches while or after doing near vision work	0	1	2	3	4	
Words appear to run together when reading	0	1	2	3	4	
Burning, itching or watery eyes	0	1	2	3	4	
Falls asleep when reading	0	1	2	3	4	
Seeing and visual work is worse at the end of the day	0	1	2	3	4	
Skips or repeats lines while reading	0	1	2	3	4	
Dizziness or nausea when doing near work	0	1	2	3	4	
Head tilts or one eye is closed or covered while reading	0	1	2	3	4	
Difficulty copying from the chalkboard	0	1	2	3	4	
Avoids doing near vision work such as reading	0	1	2	3	4	
Omits (drops out) small words while reading	0	1	2	3	4	
Writes up or down hill	0	1	2	3	4	
Misaligns digits or columns of numbers	0	1	2	3	4	
Reading comprehension low, or declines as day wears on	0	1	2	3	4	
Poor, inconsistent performance in sports	0	1	2	3	4	
Holds books too close, leans too close to computer screen	0	1	2	3	4	
Trouble keeping attention centered on reading	0	1	2	3	4	
Difficulty completing assignments on time	0	1	2	3	4	
First response is “I can’t” before trying	0	1	2	3	4	
Avoids sports and games	0	1	2	3	4	
Poor hand/eye coordination, such as poor handwriting	0	1	2	3	4	
Does not judge distances accurately	0	1	2	3	4	
Clumsy, accident prone, knocks things over	0	1	2	3	4	
Does not use or plan his/her time well	0	1	2	3	4	
Does not count or make change well	0	1	2	3	4	
Loses belongings and things	0	1	2	3	4	
Car or motion sickness	0	1	2	3	4	
Forgetful, poor memory	0	1	2	3	4	
					TOTAL SCORE	

20-24 points = suspect **25 points or more=refer for care**

For information, Contact Coleman Vision 417-782-3488 – or learn more online @ www.colemanvisioncenter.com, OEP.org or COVD.org