NP	CLXm	VSP	SphCL	TrialsDispd	1wk f/u	Finalized
PP	NoIns	EyeM	ToricCL	TrialsOrderd	NTSPAD	I/R Needed
Office Visit:		Comp B	Multi/MonoCL	P.O.L.	CL BRAND:	
Dilated @:			RGP CL	☐ 2-Week	☐ 4-Week	☐

☐ Lenso. ☐ Computer ☐ SV ☐ F -BI ☐ FT-TRI ☐ PAL

Welcome to Opticnerve Polaris. Please fill out the following form for the optometrist. Thank You.

Patient's LAST NAME	FIRST NAME	MI	Today's Date

Address	City	State	Zip

DOB	LAST 4 SSN - Primary on Insurance	CELL Phone	Alternate Phone ☐ Home ☐ Work

Email	Preferred Contact Method ☐ Email ☐ Text Message ☐ Phone Call

Patient Medical History

Check if **you** have been diagnosed with any of these conditions:

☐ Diabetes ☐ Asthma ☐ Stroke ☐ Depression
☐ Hypertension ☐ Thyroid ☐ Cancer ☐ Sickle Cell Anemia
☐ High Cholesterol ☐ Migraines ☐ Infectious Disease (HIV, TB) ☐ ***NONE***

Current Medications: ☐ ***NONE***	Medication Allergies: ☐ ***NONE***	Pregnant ? **Y N**

Patient Ocular History

Check any ocular conditions for which **you** are, or have been treated :

☐ Injury ☐ Glaucoma ☐ Detached Retina ☐ Macular Degeneration
☐ Lasik ☐ Lazy Eye ☐ Cataracts ☐ ***NONE***

Wear Contact Lenses? **Y N**

What Brand of Lenses? ____________

How long since your last eye exam?	How old are your eyeglasses?	How many hrs/day of computer work?	Contact Lens Powers?
☐ *0-1 yrs* ☐ *1-2 yrs* ☐ *>3 yrs*	☐ *0-1 yrs* ☐ *1-2 yrs* ☐ *>3 yrs*	☐ *1-3 hrs* ☐ *4-6 hrs* ☐ *>6 hrs*	(R)______ (L)______

Family Medical / Ocular History

Check if an immediate **family member** has been diagnosed with any of these conditions:

☐ Diabetes ☐ Cancer ☐ Macular Degen. ☐ Blindness
☐ Hypertension ☐ Migraines ☐ Glaucoma ☐ ***NONE***

Chief Complaints

Are you experiencing any of the following symptoms ?

☐ Distance Blur ☐ Glare ☐ Double Vision ☐ Itching ☐ Floaters
☐ Near Blur ☐ Light Sensitivity ☐ Squinting ☐ Burning ☐ Flashes
☐ Poor Night Vision ☐ Computer Strain ☐ Eye Fatigue ☐ Tearing ☐ Headaches

Social History

Employer : ____________________

Occupation : ____________________

Vision Insurance

Vision Insurance Carrier : ____________________ ☐ ***NONE***

You are the insurance policy:

☐ Subscriber ☐ Spouse ☐ Dependent

OPTIONAL FOR NEW PATIENTS: How did you learn of our office ? ☐ Insurance Website ☐ Patient Referral ☐ Advertisement ☐ Walking By Optica

Patient Signature (Parent / Guardian)

I authorize examination by the doctors of Optic Nerve Polaris and acknowledge that I can obtain the Notice of Privacy Practices of Opticnerve Polaris by request.

x ____________________