THANK YOU FOR CHOOSING FAST AVENUE VISION CENTER FOR ALL YOUR EYECARE NEEDS.
Payment for exams are due in full day. A minimum deposit of 50% is required on glasses or contact lens orders.
Please note - Insurance companies require that your patient information is updated every year. Thank you.

PATIENT INFORMATION

NAME _____

AGE_____ DATE OF BIRTH_____

Established Patients may initial here if your address has not changed _____

ADDRESS _____

CITY _____STATE _____ZIP_____
(please circle)

PHONE (H) _____ cell or work_____

INSURED'S SOCIAL SECURITY NUMBER _____

INSURANCE INFORMATION

Established Patients may initial here if your address has not changed _____

EYE INSURANCE _____

MEDICAL INSURANCE _____

FAMILY PHYSICIAN _____ last visit _____/20_____

OCCUPATION_____

HOBBIES _____

HOW DID YOU HEAR ABOUT US? _____

DATE OF LAST EYE EXAM:_____(If you are a new patient)

ARE WE SEEING YOU TODAY FOR A ROUTINE EYE EXAM ☐ yes
or for a MEDICAL PROBLEM? ☐ yes

Please provide a brief explanation of the problem you are experiencing:

_____

_____

_____

When and what time did this problem begin? _____

_____

Would you benefit from Rx sunglasses? yes no

Are you interested in contact lenses? yes no

SIGNATURE ON FILE

I request that payment of authorized Medicare or other insurance be made to Paul S. DeLange, O.D. and Associates for any services furnished. I authorize any holder of medical information about me to release to HCFA and its agents any information needed to determine these benefits payable for related services.

Signature _____ Date_____

CC:

MEDICAL HISTORY

DO YOU HAVE GLASSES? ☐ yes or ☐ no

DO YOU WEAR CONTACTS? ☐ yes or ☐ no

HAVE YOU HAD CATARACT SURGERY?
☐ yes or ☐ no

HAVE YOU HAD LASIK SURGERY? ☐ yes or ☐ no

ARE YOU TAKING ANY MEDICATION(S):
☐ yes or ☐ no IF YES, PLEASE LIST

_____

_____

_____

_____

ARE YOU EXPERIENCING ANY OF THE FOLLOWING:

- ☐ DRY EYE
- ☐ NEAR VISION BLUR
- ☐ DISTANCE VISION BLUR
- ☐ INTERMEDIATE VISION BLUR
- ☐ DOUBLE VISION
- ☐ HEADACHES
- ☐ SEEING SPOTS/LINES
- ☐ SEEING FLASHES
- ☐ SEEING HALOS
- ☐ EYE STRAIN
- ☐ PROBLEMS WITH GLARE/REFLECTION

DO YOU SUFFER FROM OR KNOW YOUR FAMILY HISTORY REGARDING ANY OF THE FOLLOWING?

CATARACTS	☐SELF	☐FAMILY
HIGH BLOOD PRESSURE	☐SELF	☐FAMILY
SEIZURES	☐SELF	☐FAMILY
DIABETES	☐SELF	☐FAMILY
HIGH CHOLESTEROL	☐SELF	☐FAMILY
MULTIPLE SCLEROSIS	☐SELF	☐FAMILY
CARDIAC DISEASE	☐SELF	☐FAMILY
SICKLE CELL ANEMIA	☐SELF	☐FAMILY
ALLERGIES	☐SELF	☐FAMILY
GLAUCOMA	☐SELF	☐FAMILY
LAZY EYE	☐SELF	☐FAMILY
CROSSED EYE	☐SELF	☐FAMILY
COLOR BLINDNESS	☐SELF	☐FAMILY
MACULAR DEGENERATION	☐SELF	☐FAMILY
RETINAL DETACHMENT	☐SELF	☐FAMILY
ARTHRITIS	☐SELF	☐FAMILY
ANXIETY, ETC.	☐SELF	☐FAMILY
RESPIRATOR/ASTHMA	☐SELF	☐FAMILY

OTHER: _____

Physician's Signature: _____