Riverside Eye Center

14410 US Highway 1
Sebastian, FL 32958
Phone: (772) 589-8111
Fax: (772) 589-7561

Welcome to Riverside Eye Center, a leader in comprehensive ophthalmology serving the Space and Treasure Coasts for over 26 years. Your vision is our priority and we are honored you have chosen to entrust us with your sight. We are dedicated to providing quality healthcare and exceptional customer service to our patients in a professional, warm and friendly environment.

Sight

We place great value in our patients "seeing" the results. Welcome to Riverside Eye Center. Our caring, compassionate physicians, Dr. Brett Steinwand, Dr. Stephen Winslow, Dr. Norman Meyer and Dr. Camilla Dunn, offer total and complete eye care including routine eye exams for glasses and contacts, as well as comprehensive medical exams and treatments. Our doctors and surgeons have extensive experience treating conditions such as Cataracts, Macular Degeneration, Glaucoma, Diabetic Retinopathy, Retinal Detachment, corneal conditions, Dry Eye Syndrome, including surgical intervention and laser treatments. Our expert surgeons have performed thousands of surgeries in our AAAHC accredited and Medicare certified ambulatory surgery center, conveniently located right next door. Our physicians are dedicated to providing each patient with a personalized treatment plan that is tailored to meet their individual needs to improve and maintain their visual health for many years to come. *We are focused on you!!*

Spectacles

At Riverside Optical Center, which is easily accessible to our patients, we offer frames to fit anyone's budget or style. Our onsite Optician is here to assist our patients with any optical repairs or simply help you choose the perfect fit.

Sound

Hearing loss affects 30 million Americans, eighty percent (80%) of which go undiagnosed and untreated. Clinical studies have shown a correlation between vision and hearing loss. At Hearing Healthcare at Riverside Eye Center, our patients receive complimentary hearing evaluations on a yearly basis with their eye exams as part of our total care package, and they are invited to bring their family and friends. We offer state of the art solutions for hearing loss at affordable prices.

Skin

The Center for Facial Aesthetics provides medical strength products and treatments to decrease the signs of aging and help restore your skins youthful appearance. We offer Jane Iredale Skin Care Cosmetics, ZO Skin Care, Chemical Peels, Rosacea treatments, Facials, waxing, sun protection, as well as Botox, Dermal Fillers, Kybella, Microdermabrasion and Cosmetic Eyelid Rejuvenation with our licensed medical esthetician on staff to help you attain Total Skin Care for a difference you will see.

Please arrive 10 minutes prior to your scheduled appointment and bring the completed enclosed forms with you.

Appointment information:	
☐ Brett Steinwand, M.D. ☐ Norman Meyer, M.D. ☐ Stephen Winslow, M.D. ☐ Camilla Dunn, O.D.	Monday Tuesday Wednesday Thursday Friday Date: _____ Time: _____ ☐am ☐pm

If you have any questions, please call us at 772-589-8111.

We look forward to meeting you and providing you with the *Best Care in Sight.*

Riverside Eye Center

PATIENT REGISTRATION

Name: _____
First Middle Last

Date of Birth: _____ **SS #:** _____ **Marital:** Married Single Divorced Widowed Other **Sex:** Male Female

Race: ☐ White ☐ Black ☐ American Indian/Alaskan Native ☐ Native Hawaiian/Pacific Islander ☐ Asian ☐ Other

Ethnicity: ☐ Not Hispanic ☐ Hispanic / Latino ☐ Unreported/Refuse to Report

Local Address: _____
Street or PO Box City State Zip

Northern Address: _____
(if different than above) Street or PO Box City State Zip

Cell Phone: _____ **Home Phone:** _____ **Northern Phone:** _____

E-Mail: _____

Occupation: _____ **Place of Employment:** _____ **Phone #:** _____

Emergency Contact: _____ **Relationship:** _____
Name Phone

PCP / Family Physician: _____ **Phone #:** _____

Preferred Local Pharmacy: _____ **Location:** _____ **Phone #:** _____

Insurance Information

Please give cards to receptionist to make copies. Thank you.

Primary Insurance: _____ **Secondary Insurance:** _____
Primary Policy Holder: _____ **Primary Policy Holder:** _____
ID #: _____ **Relation:** _____ **ID #:** _____ **Relation:** _____
DOB: _____ **SS#:** _____ **DOB:** _____ **SS#:** _____

Office Policy Regarding Payment

We will file your insurance on your behalf. We accept Medicare assignment and participate in most major plans. You are responsible for paying deductibles, co-pays, as well as fees for non-covered services at each visit. Patients with Managed Care plans are responsible for obtaining authorization from your primary care physician, if applicable. You are responsible for any unauthorized visits and non-covered services.

Which Doctor are you here to see?

☐ Brett E. Steinwand, M.D. ☐ Stephen J. Winslow Jr., M.D.
☐ Norman I. Meyer, M.D. ☐ Camilla J. Dunn O.D.

Please indicate the reason for your visit:

☐ Cataract Check ☐ Diabetic Exam ☐ Need New Glasses ☐ Hearing Health
☐ Glaucoma Exam ☐ Macular Degeneration ☐ Need New Contacts ☐ Skin Care
☐ Having a Medical Problem ☐ Routine Exam / No problems ☐ Other: _____

How did you hear about us?

(check all that apply)

☐ Family / Friend: _____ ☐ Screening: _____
☐ Eye Doctor: _____ ☐ Insurance Plan: _____
☐ Primary Care MD: _____ ☐ Other: _____

PATIENT OR GUARDIAN SIGNATURE: _____ Date: _____

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Routine Eye Exams vs. Medical Eye Exams

Please Read Before Your *Eye Examination*

Regular eye examinations are important to maintain your vision for your lifetime. It is important that you be aware of your insurance benefits and how they apply to your visit, so you will know how billing will be handled. Ultimately, it is your responsibility to know what your own insurance plan covers. Some medical insurance plans provide a benefit for one routine, preventive eye examination per year. We hope this information will help you to understand how your visit is submitted to your insurance for today's visit and future visits with Riverside Eye Center.

Benefits may vary based upon the reason for your visit. Your description of your eye condition will help us to determine whether your visit to the clinic is defined as "Routine" or "Medical". Your symptoms and eye examination findings will determine how your visit is coded and billed to your insurance.

Routine Eye Examinations A "routine eye exam" takes place when you come for an eye examination without any medical eye problem. The doctor screens the eyes for disease and will check your vision.

Medical Eye Examinations Exams for medical care which are for evaluation of a medical-related complaint or follow up of an existing condition are examples of an eye examination that would be billed to your medical insurance. Examples that will necessitate your visit being submitted as a medical exam include diabetes mellitus, eye irritation, dry eyes, allergies, floaters, glaucoma, cataract, eye muscle imbalance, "lazy eye", macular degeneration, and others. Please note that if you have diabetes mellitus and would like us to send a letter to your primary care physician regarding your eye examination, the visit will be coded as a "medical eye examination".

It is your responsibility to tell us what insurance benefit you intend to use If your medical insurance allows for a routine, annual exam, or you have a separate vision insurance, we need to be aware of this coverage prior to your exam. If you report symptoms during your visit related to an eye problem, disease, or injury, or your doctor determines that your problem falls under the category of a "medical eye examination", your visit will be billed as a *medical* exam instead of a *routine* exam, which will be subject to co-pays and deductibles according to your plan. If you have coverage with a separate *Vision Plan,* such as VSP, we will be happy to file the claim for you, provided we are informed of the insurance prior to the visit. In most cases, our medical doctors, Dr. Steinwand, Dr. Winslow and Dr. Meyer only see patients for medical exams, while our Board-Certified Optometrist, Dr. Dunn sees patients for exams which are routine in nature.

In summary, how your eye exam will be submitted to your insurance carrier will depend not only upon what you tell the doctor, but also what the doctor finds upon examination. Your signature below indicates that you understand the differences between routine and medical eye examinations and the potential implications of these differences on the type of exam that gets billed and the potential for fees that may include co-pays, deductibles, and/or co-insurance fees. You understand that you are responsible for any of these fees as determined by your insurance carrier. If you have any questions, please ask a member of our staff.

_____ _____

Signature **Date**

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Signature on File, Assignment of Benefits, Financial Agreement

Patient Name *(print)* _____ Date of Birth _____

1. **MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to Riverside Eye Center for services furnished me by Riverside Eye Center. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the CMS-1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. Riverside Eye Center accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.

2. **MEDIGAP:** I understand that if a MediGap policy or other health insurance is indicated in Item 9 of the CMS-1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to Riverside Eye Center, if possible or otherwise to me.

3. **RELEASE OF INFORMATION:** Riverside Eye Center may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to Riverside Eye Center for reimbursement for services rendered, and (2) any health care provider for continued patient care. Riverside Eye Center may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statute or regulation. A copy of this authorization may be used in place of the original.

4. **OTHER INSURANCE:** I understand that Riverside Eye Center maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office and that Riverside Eye Center has no contract, expressed or implied, with any plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by Riverside Eye Center if I belong to a plan that does not appear on the above mentioned list.

5. NON-COVERED SERVICES: I understand that Riverside Eye Center contracts with health care service plans (i.e., HMOs, PPOs) relate only to items and services which are covered by the health care service plans. Accordingly, the Undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the healthcare service plan furnishes to the patient and treatment or tests not authorized by the health care service plan. Refraction fees, which are typically considered a non-covered service by medical insurance companies, will be collected at the time the service is rendered. If my insurance pays for this service, Riverside Eye Center will reimburse me for any overpaid amount. Furthermore, the undersigned agrees to cooperate with Riverside Eye Center to obtain necessary health care service plan authorizations.

6. FINANCIAL AGREEMENT: I agree that in return for the services provided to the patient by Riverside Eye Center, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Riverside Eye Center for payment. Fees for services not covered by my insurance, deductibles, copays and coinsurances will be collected at the time of service. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, are hereby assigned to Riverside Eye Center. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Riverside Eye Center at the time services are rendered. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill. If an account is assigned to collections for further legal action, I acknowledge that I am responsible for 100% of any collection agency fees and/or attorney fees. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate.

Patient Signature or Authorized Party _____ Date _____

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HEALTH INFORMATION RELEASE FORM

In order to assist you in receiving your health information from **Riverside Eye Center**, please complete this form.

I authorize the persons listed below to have access to any and all of my health information, including eyeglass prescription, contact lens prescription, diagnosis and treatment, HIV, drug and alcohol abuse and psychiatric records. **Riverside Eye Center** is permitted to share any medical information with them, including test results and information disclosed during office visits.

Persons or organization authorized to receive my medical information (full name and phone number):

_____ _____

_____ _____

_____ _____

You may notify me or the parties listed above with normal test results, appointment reminders and other information regarding my health information as follows:

Message on answering machine (Phone number_____)
Message on cell phone (Phone number _____)
Other_____)

MY RIGHTS:
I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form to take part in a research study or to receive health care when the purpose is to create health care information for a third party.

I may revoke this authorization *in writing.* If I did, it would not affect any actions already taken **Riverside Eye Center** based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

- Fill out a revocation form. A form is available from the Administrator, OR
- Write a letter to the Administrator.

Once health care information is disclosed, the person or organization that received it may re-disclose it. Privacy laws may no longer protect it.

Riverside Eye Center complies with all HIPAA and other federal privacy regulations. I acknowledge that I have been made aware of my rights to review or obtain a copy of the policies.

Patient - Print Name_____ Witness - Print Name_____

Patient – Signature_____ Witness – Signature_____

Patient - Date of Birth_____ Date_____

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NOTICE OF PRIVACY PRACTICES

WRITTEN ACKNOWLEDGEMENT FORM

I am a patient of **Riverside Eye Center, PLLC** and/or **Riverside Surgery Center, Inc**. I hereby acknowledge receipt of Riverside Eye Center, PLLC and/or Riverside Surgery Center's Notice of Privacy Practices.

Name [please print]: _____

Signature: _____

Date: _____

OR

I am a parent or legal guardian of _____ [patient name]. I hereby acknowledge receipt of **Riverside Eye Center, PLLC**'s and/or **Riverside Surgery Center, Inc.**'s Notice of Privacy Practices with respect to the patient.

Name [please print]: _____

Relationship to Patient: ☐ Parent ☐ Legal Guardian

Signature: _____

Date: _____

Effective 9/23/13
Updated 12/31/2015

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Our Office Philosophy

We feel it is extremely important to spend as much time as necessary with each patient to fully address your eye situations. This enables us to explain our findings and recommendations in depth and answer any questions you may have during your visit. Our staff schedules patients accordingly and we try to be as efficient as possible in order to expedite your visit. Please be assured that we value your time. Given the unpredictable and sometime emergent nature of our work, occasionally there may be a prolonged waiting time. On many occasions, we are delayed for such matters as patients' medical problems, which require immediate attention. These issues are unforeseen and need to be addressed as they arise. We make every effort to see our patients in a timely manner and minimize any delays. Please understand that when you are being seen you will receive the same thorough treatment.

Our office is staffed to adequately meet the needs of our patients. Therefore when patients are scheduled and do not show up for their appointment our staffing is disrupted. For this reason we ask that if you need to cancel an appointment, please give us at least 24 hours notice. If you do not show up for an appointment or call to notify us, a $25.00 fee may be assessed.

Initials
_____

Acknowledgement
I have read and understand the above statement.

Notice of Non-Covered Service – Refraction

A refraction error is an error in the focusing of light by the eye and a frequent reason for reduced visual acuity. Refraction is the process used to determine the eye's refractive error. Refraction is an essential part of a comprehensive eye examination, but it is NOT a covered benefit with Medicare or most other insurance plans. This test is routinely performed once per year and/or if there are any complaints of, or changes in your vision.

Effective February 1,2020, the refraction fee is $45.00. This fee will be collected in addition to any co-payments at the time of service.

Initials
_____

Acknowledgement
I have read the above information and understand that the refraction is a non-covered service. I accept full responsibility for the cost of the refraction. I further understand that any co-payments and/or deductibles under my plan are separate from and not included in the fee for the refraction.

Information regarding dilating drops

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the ophthalmologist to get a better view of the inside of your eye. Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your ophthalmologist to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it's best if you make arrangements not to drive yourself. Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

Initials
_____

I hereby authorize my doctor and/or such assistants as may be designated by him/her to administer dilating eye drops. The eye drops are necessary to diagnose my condition.

_____ _____

Patient's Signature **Date**

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Goals for Your Vision

Name_____ Date_____

We have many options to treat various conditions of the eye. Many times the best option to choose depends on the goals and lifestyles of our patients. For example, a patient who is sedentary due to other health restrictions may have as a goal to be able to read and see the television more clearly. A more active patient may want to be completely free of glasses for driving, and outdoor activities. This lifestyle questionnaire helps us determine which of our many procedures and treatment may be most beneficial to you.

1. Are you interested in seeing well at a distance without glasses?
   [ ] Prefer to wear no distance glasses
   [ ] Not important to me. I would not mind wearing glasses for distance.

2. Are you interested in seeing up close (reading, needlework) without glasses?
   [ ] Prefer no reading glasses
   [ ] Not important to me. I do not mind wearing glasses for reading.

3. What is / was your occupation?_____

4. What are your hobbies? _____

5. When are your glasses/contacts most bothersome to you? (check all that apply)
   [ ] Never
   [ ] Boating/Fishing
   [ ] Sports (Golf, tennis, exercising)
   [ ] Reading
   [ ] Needlework (Sewing, knitting, crocheting)
   [ ] Middle of the night
   [ ] Driving
   [ ] Watching TV
   [ ] Working on the computer

6. What zone of vision is most critical to your lifestyle?
   [ ] **Zone 1:** Reading newsprint, phonebook, maps, sewing
   [ ] **Zone 2**: Headlines, computer, menus, price tags
   [ ] **Zone 3**: TV, Cooking, Cleaning, Board games, dominoes
   [ ] **Zone 4:** Daytime driving, Golf, Reading road signs
   [ ] **Zone 5**: Night driving, Movies, Star gazing

MEDICAL HISTORY QUESTIONNAIRE

Riverside Eye Center

Today's Date:_____

Name: _____ Date of Birth: _____ Age: _____

Height: _____ Weight: _____ Allergies: _____

PCP/Family Physician:_____ Phone: _____

Preferred Local Pharmacy:_____ Location: _____ Phone: _____

REVIEW OF SYMPTOMS:

Primary Reason for Today's Visit: [ ]Cataract [ ]Glaucoma [ ] Diabetes

[ ]Macular Degeneration [ ]Dry Eye [ ]Blurred Vision [ ]Other: _____

Do you presently have any problems in the following areas?

Eyes	**YES**	**NO**		**YES**	**NO**
Loss or blurred vision	[ ]	[ ]	Respiratory (lungs, breathing)	[ ]	[ ]
Loss of side vision, double vision	[ ]	[ ]	Gastrointestinal (stomach, intestines)	[ ]	[ ]
Itching, burning, or discharge	[ ]	[ ]	Genitoutinary (genitals, kidney, bladder)	[ ]	[ ]
Redness	[ ]	[ ]	Musculoskeletal (muscles, joints)	[ ]	[ ]
Gritty feeling, dryness or tearing	[ ]	[ ]	Integument (skin, breast)	[ ]	[ ]
Glare / light sensitivity, or halos	[ ]	[ ]	Neurological (headache)	[ ]	[ ]
Eye pain or soreness	[ ]	[ ]	Psychiatric	[ ]	[ ]
Infection of eye lashes or lid, styes	[ ]	[ ]	Endocrine (hormones, glands)	[ ]	[ ]
Ears, Nose, Mouth, Throat	[ ]	[ ]	Hematologic / Immunologic (blood)	[ ]	[ ]
Cardiovascular (heart, blood vessels)	[ ]	[ ]	Seasonal Allergies (hay fever, etc)	[ ]	[ ]

PAST HISTORY (EYES)	**YES**	**NO**	**COMMENTS**
Eye drops currenty in use (list on lines to the right)	[ ]	[ ]	_____
Allergies to eye drops (list on lines to the right)	[ ]	[ ]	_____
History of cataract, glaucoma	[ ]	[ ]	_____
History of cross / lazy eye	[ ]	[ ]	_____
Eye injury or other disease	[ ]	[ ]	_____
Eye Surgery	[ ]	[ ]	_____

PAST MEDICAL HISTORY

Major Illnesses:	**YES**	**NO**		**YES**	**NO**		**YES**	**NO**
High Blood Pressure	[ ]	[ ]	Chronic Cough	[ ]	[ ]	Blackouts	[ ]	[ ]
Low Blood Pressure	[ ]	[ ]	Exposure to TB	[ ]	[ ]	Blood Disorder	[ ]	[ ]
Anemia	[ ]	[ ]	Asthma / Wheezing	[ ]	[ ]	Rheumatic Fever	[ ]	[ ]
Heart Murmer	[ ]	[ ]	Headaches	[ ]	[ ]	Meningitis, Polio	[ ]	[ ]
Heart Palpatations	[ ]	[ ]	Cancer	[ ]	[ ]	Bruise or Bleed Easy	[ ]	[ ]
Irregular Heart Beat	[ ]	[ ]	Stroke	[ ]	[ ]	Blood Clots	[ ]	[ ]
Pacemaker	[ ]	[ ]	Ulcer / Hiatal Hernia	[ ]	[ ]	Back Problems	[ ]	[ ]
Chest Pain / Angina	[ ]	[ ]	Thyroid Disease	[ ]	[ ]	Abnormal Chest X-Ray	[ ]	[ ]
Sickle Cell Anemia	[ ]	[ ]	Nervous Disorder	[ ]	[ ]	Aids / HIV	[ ]	[ ]
Diabetes	[ ]	[ ]	Epilepsy / Seizures	[ ]	[ ]	Immune Deficiency	[ ]	[ ]
Hypoglycemia	[ ]	[ ]	Dizziness	[ ]	[ ]	Hepatitis / Liver Problems	[ ]	[ ]
Blindness	[ ]	[ ]	Kidney Problems	[ ]	[ ]	Heart Attack (date_____)	[ ]	[ ]
Deafness	[ ]	[ ]	Arthritis	[ ]	[ ]	Congestive Heart Failure	[ ]	[ ]
Shortness of Breath	[ ]	[ ]	Intestinal Disease	[ ]	[ ]	Bronchitis / Emphysema	[ ]	[ ]
Recent Cough / Cold	[ ]	[ ]	Psychiatric Disorder	[ ]	[ ]	Pneumonia / Lung Problems	[ ]	[ ]

Major illness not listed above: _____

List any major surgical procedures: _____

PLEASE CONTINUE ON BACK SIDE

DO YOU HAVE ANY MEDICATION ALLERGIES? Yes No (list) _____

[ ] Please see attached listing of medications I am currently taking.

List all medications that you are currently taking (only if you did not provide a list of your medications)

Medication	Dosage / Regimen

Medication	Dosage / Regimen

FAMILY HISTORY-

OCULAR	**YES**	**NO**	**MEDICAL**	**YES**	**NO**
Blindness	[ ]	[ ]	Diabetes	[ ]	[ ]
Cataract	[ ]	[ ]	Arthritis, Lupus, Etc.	[ ]	[ ]
Glaucoma	[ ]	[ ]	Other (list) _____		
Macular Degeneration	[ ]	[ ]	_____		
Retinal Detatchmant	[ ]	[ ]	_____		

SOCIAL HISTORY

OCULAR

Have you ever tried to wear contacts? **Yes No** If yes, did you have trouble wearing them? **Yes No**

My vision causes problems with: [ ]Driving [ ]Night Vision [ ]Reading [ ]Sports/Outdoor Activities

GENERAL

Do you drink alcohol? **Yes No** If yes, how much? _____ How Often? _____

Do you smoke? **Yes No** If yes, how many packs/day? _____

Have you ever smoked? **Yes No** If yes, how long? _____ When did you quit? _____

Have you ever used "illicit" or "Recreational" Drugs? **Yes No**

If yes, what type? _____ How much? _____

Have you had a blood transfusion? **Yes No** If yes, when? _____

Have you been in contact with a person who had a sexually transmitted disease? **Yes No**

Do you have difficulty with any of the following?	**YES**	**NO**
Feeling unsafe driving day or night due to quality of vision with glare?	[ ]	[ ]
Halos, star bursts, or glare from oncoming headlights at night?	[ ]	[ ]
Your glasses always seem dirty even after you just clened them?	[ ]	[ ]
Doing fine handwork, such as sewing, knitting or carpentry?	[ ]	[ ]
Daytime driving?	[ ]	[ ]
Sports activities such as bowling, fishing, tennis or golf?	[ ]	[ ]
Reading a newspaper or book?	[ ]	[ ]
Reading a large print book or the numbers on a telephone?	[ ]	[ ]
Recognizing people when they are too close to you?	[ ]	[ ]
Seeing steps, stairs, or curbs?	[ ]	[ ]
Writing checks or filling out forms?	[ ]	[ ]
Playing games such as dominos or cards?	[ ]	[ ]
Reading small print on medicine bottles or telephone books?	[ ]	[ ]
Looking at or reading recipes?	[ ]	[ ]
Watching television?	[ ]	[ ]
Night time driving?	[ ]	[ ]
Trouble adjusting to dark rooms after bright sunlight?	[ ]	[ ]

Other vision complaints: _____

Patient's Signature: _____ Date: _____

Do not write below this line. For office use only.

History Reviewed: [ ] No Changes [ ] Additions as noted

Physician's Signature: _____ Date: _____