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 provide 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. Our caring, compassionate physicians, Dr. Brett Steinwand, Dr. Stephen Winslow, and Dr. William “Bert” Misner 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, edema, corneal conditions, and Dry Eye Syndrome. Our expert surgeons have performed thousands of surgeries and laser treatments in our AAAHC accredited and Medicare certified ambulatory surgery center, conveniently located right next door. Our physicians provide 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.

Spectacles

At Riverside Optical Center, we offer frames to fit anyone's budget or style. Our onsite Optician and Stylist are here to assist our patients with any optical repairs or simply help to choose the perfect fit. Riverside Optical is conveniently located in main lobby of Riverside Eye Center.

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 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 grade products and treatments to decrease the signs of aging and help restore your skin’s youthful appearance. We offer chemical peels, Rosacea treatments, facials, waxing, VI Peels, Microdermabrasion, ZO Skin Care Products, Image Skincare Products, Botox, Juvéderm Dermal Fillers, Kybella, and more. Our Licensed Medical Aesthetician, Danna, will 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. ☐ Stephen Winslow, M.D. ☐ William “Bert” Misner, 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.*

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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 the billing will be handled. Ultimately, it is your responsibility to know what your own insurance plan covers. While Medicare Part B and commercial medical insurance plans do not typically provide benefits for routine eye examinations, many Medicare Advantage plans now carry vision riders with separate vision insurance companies such as VSP, Eyemed or Spectera. 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". While scheduling your appointment, the description of your symptoms as well as your vision and medical insurance plan information will determine how your visit is scheduled and which doctor you will be scheduled with.

Routine Vision Examinations A "Routine Vision Exam", sometimes known as a "glasses exam" takes place when you come for an eye examination without any medical complaint. Dr. Steinwand and Dr. Winslow typically do not perform routine Vision Examinations. During a Routine Vision Exam, our optometrist, Dr. Misner, performs a dilated Vision Exam to screen for disease and provides a prescription for glasses and/or contact lenses. If non-emergent medical symptoms are reported or found during your Routine Vision Examination, you will be scheduled for a follow up medical examination to be billed under your medical insurance. During this follow up visit, your medical conditions will be addressed. Some Medicare Advantage HMO plans require that you have a routine vision exam with an Optometrist before they will authorize a medical exam with an Ophthalmologist.

Medical Eye Examinations A "Medical Eye Exam" is for the evaluation of a medical-related complaint or follow up of an existing medical eye condition. This type of exam is billed to your medical insurance. Conditions that meet the criteria for your visit being submitted as a medical exam include eye irritation, dry eyes, allergies, floaters, glaucoma, cataracts, eye muscle imbalance "lazy eye", macular degeneration, diabetes (in some cases) and others.

It is your responsibility to provide us with the information for the insurance benefits you intend to use. To ensure that you are scheduled with the proper physician and applicable authorizations are obtained, we must be informed of all insurance coverages prior to your visit. Failure to provide us with the correct information may result in higher patient costs.

Your signature below indicates that you understand the differences between routine and medical eye examinations. Providing insufficient insurance information may result in higher out of pocket costs including copays, deductibles, coinsurance or non-covered services. 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**

PATIENT REGISTRATION

Riverside Eye Center

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

Secondary Address: ______________________________
(if different than above) Street or PO Box City State Zip

Primary Phone: __________ **Secondary Phone:** __________ **Alternate Phone:** __________

E-Mail Address: ______________________________

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 HMO plans and VA patients: You are responsible for obtaining authorization from your primary care physician, if applicable. You are responsible for any unauthorized visits and non-covered services.
Please see the "Signature on File, Assignment of Benefits & Financial Agreement" for further details.

Which Doctor are you here to see?

☐ Brett E. Steinwand, M.D. ☐ Stephen J. Winslow Jr., M.D. ☐ William "Bert" Misner, 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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Signature on File, Assignment of Benefits, Financial Agreement, & Patient Rights and Responsibilities

We are committed to providing you with the highest level of service and quality care. If you have medical insurance, we will strive to help you receive your maximum allowable benefits. To achieve these goals, we need your assistance and understanding of our financial policy. Ultimately, however, all financial liability rests with the patient.

Our office participates with most major insurance plans. We will submit a **MEDICAL and/or SURGICAL** claim to your health insurance. We will submit a **VISION** claim to your vision insurance. Our charges for examinations are available upon request. 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. Riverside Eye Center has no contract, expressed or implied, with any plan that does not appear on the list. The undersigned agrees that they are individually obligated to pay the full charges of all services rendered by Riverside Eye Center if they belong to a plan that does not appear on the list.

MEDICARE: I request that payment of authorized Medicare benefits be made on my behalf to Riverside Eye Center for services furnished to me by Riverside Eye Center. 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 for the deductible, coinsurance, and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier. If applicable, I request that payment of authorized secondary insurance benefits be made on my behalf to Riverside Eye Center, if possible or otherwise to me.

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.

FOR BENEFICIARIES OF CONTRACTED / PARTICIPATING INSURANCES: I request that payment of authorized insurance benefits be made on my behalf to Riverside Eye Center for services furnished to me by Riverside Eye Center. Riverside Eye Center accepts the charge determination of the contracted insurance carrier as the full charge, and I am responsible for the deductible, coinsurance, and non-covered services. Coinsurance and deductible are based upon the charge determination of the insurance carrier. If applicable, I request that payment of authorized secondary insurance benefits be made on my behalf to Riverside Eye Center, if possible or otherwise to me.

FOR BENEFICIARIES OF NON-CONTRACTED / NON-PARTICIPATING INSURANCES: I request that payment of authorized insurance benefits be made on my behalf to Riverside Eye Center for services furnished me by Riverside Eye Center. Riverside Eye Center is <u>not contractually required</u> to accept the charge determination of the insurance carrier as the full charge. I am responsible for the difference between the billed amount and amount that the insurance pays. If applicable, I request that payment of authorized secondary insurance benefits be made on my behalf to Riverside Eye Center, if possible or otherwise to me.

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.

IT IS THE PATIENT'S/PARENT'S/GUARDIAN'S RESPONSIBILITY TO:

- Be familiar with the benefits of your plan, including co-pays, co-insurance, and deductibles.
- Bring all your current insurance cards to all visits.
- Provide our office with current information including address, phone numbers and insurance information.
- Obtain referral or authorization for your visit. If you have a managed care plan that requires a referral to see a specialist, you must obtain a referral for your visit in our office to be covered under your medical insurance. If you do not have the valid referral and still wish to be seen, you will be asked to pay for the visit prior to your examination.
- Be aware that for all services rendered to minor/dependent patients, we will look to the adult accompanying the patient and/or the parent or guardian with whom the child resides for payment. In cases of separation or divorce, when presenting insurance cards for a dependent enrolled under a subscriber other than you, please be prepared to supply their name, address, phone number, date of birth and social security number. We request that you inform the subscriber that their insurance has been used.

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We appreciate and expect prompt payment in full for any balance due.
We accept cash, checks, CareCredit and all major credit cards for services.

- **REFRACTION EXAMINATION FEE:** A refractive error is when light rays are not brought into sharp focus and a frequent reason for reduced visual acuity. Refraction is the process used to determine the eye's refractive error. This test is routinely performed once per year and/or if there are any complaints of, or changes in your vision. Refraction is an essential part of a comprehensive eye examination but is NOT a covered benefit with Medicare or most other insurance plans. Effective February 1,2020, the refraction fee is $45.00. This fee will be collected in addition to any co-pays, deductibles or coinsurance and is payable at the time of service. If your insurance pays for the service, Riverside Eye Center will reimburse you for any overpaid amount.
- **CANCELLATION AND NO-SHOW POLICY:** Our goal is to provide quality ophthalmic care in a timely manner. We have implemented a no show and cancellation policy which enables us to better utilize available appointments for our patients in need of ophthalmic care. The following policy refers to patients who fail to appear for their scheduled office appointments, procedure appointments, or surgical appointments. These fees are not covered by insurance and are therefore the sole responsibility of the patient or legal guardian.
  Office Visit Appointments:
  - There will be a $25.00 charge if you fail to show for any scheduled clinic appointments or cancel the same day as your appointment. *

  Surgery Center Appointments:
  - Cancellations less than one (1) week before scheduled surgery at Riverside Surgery Center, Inc. will be charged a $200 cancellation fee. *
  - Cancellations less than seventy-two (72) hours prior to surgery scheduled at Riverside Surgery Center, Inc. will be charged a $300 cancellation fee. *
  - If you fail to provide advance notice of cancellation AND fail to arrive for surgery (no-show) scheduled at Riverside Surgery Center, Inc., a $500 no-show fee will be charged. *

  * Legitimate emergencies will be taken into consideration.
- There is a $25.00 charge for completing all forms, including your DMV form.
- In accordance with your insurance contract, you are required to pay your co-pay, deductible, coinsurance, or fees for non-covered services at each visit. If you do not make your co-payment at the time of the visit, you will be charged a $10 administrative billing fee.
- **RETURNED CHECK FEE:** All returned checks are subject to a $30.00 returned check fee.
- **COLLECTIONS FEE:** If your account is turned over to our collection agency, you are responsible for a $25.00 collections fee, 100% of any attorneys and/or court costs incurred due to attempts to collect the debt. You may not schedule an appointment until your balance has been paid in full or suitable payment arrangements have been made.

I have read and understand the above financial policy and I authorize insurance payments for services rendered are made on my behalf to Riverside Eye Center, PLLC.

______________________________________ ____________________

Signature of patient/guardian/parent Date

____

Printed name of patient

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HEALTH INFORMATION RELEASE FORM

I authorize the persons listed below to have access to 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

PREFERRED PHONE NUMBERS

Home Phone: (________) _________ - _____________ May we leave messages on voicemail which may include test results or other medical information? ☐Yes ☐No	Cell Phone: (________) _________ - _____________ May we leave messages on voicemail? ☐Yes ☐No May we send text messages? ☐Yes ☐No

PERSONS OR ORGANIZATIONS AUTHORIZED TO RECEIVE MY MEDICAL INFORMATION (FULL NAME AND PHONE NUMBER):

Name:	Phone:
Name:	Phone:

MY RIGHTS

I understand I do not have to sign this authorization 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 were to obtain insurance. Two ways to revoke this authorization are: 1. Fill out a revocation form. A form is available from the Administrator or 2. 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.

NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGEMENT FORM

I am a **patient or parent/legal guardian** 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.

Patient - Print Name	
Signature	Date
IF PATIENT IS A MINOR:	
Parent/Legal Guardian Name	Relationship

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	Date of Birth
Patient - Signature	Date

REQUEST TO RELEASE MEDICAL RECORDS TO RIVERSIDE EYE CENTER

Person/Organization requested information from: ____

I hereby authorize the use or disclosure of my individually identifiable health information to be sent to Riverside Eye Center to assist in my ongoing treatment. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. I understand that if my medical record contains information about drug and/or alcohol abuse, psychiatric, venereal disease, social service, hepatitis B testing/treatment, and/or sensitive information, I agree to its release. **This authorization remains in effect until revoked.**

Please fax **all** patient records to: 772-589-7561

Please be sure to include: ____
(Description of specific records needed)

Patient Signature: Date:

MEDICAL HISTORY QUESTIONNAIRE

Riverside Eye Center

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 [ ]Diabetic Eye Exam [ ]Glaucoma [ ]Macular Degeneration
[ ]Dry Eye [ ]Blurred Vision [ ]Other:

HISTORY OF PRESENT ILLNESS

Do you presently have any problems in the following areas?

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

PAST HISTORY (EYES)

	YES	**NO**	**COMMENTS**		**YES**	**NO**	
Eye drops currenty in use	[ ]	[ ]	____________	History of cross / lazy eye	[ ]	[ ]	____________
Allergies to eye drops	[ ]	[ ]	____________	Eye injury or other disease	[ ]	[ ]	____________
History of cataract, glaucoma	[ ]	[ ]	____________	Eye Surgery	[ ]	[ ]	____________
Have you ever worn contacts?	[ ]	[ ]		If yes, did you have trouble wearing contact?	[ ]	[ ]	

INFORMATION REGARDING DILATING DROPS

Dilating drops are used to dilate or enlarge the pupils to allow the ophthalmologist to get a better view of the inside of your eye. Dilating drops frequently 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 predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it is best if you plan not to drive yourself. Adverse reaction, such as acute angle-closure, may be triggered by the dilating drops. This is extremely rare and treatable with immediate medical attention.

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 Initials: _________

PAST MEDICAL HISTORY (SYSTEMIC)

Major Illnesses:	**YES**	**NO**		**YES**	**NO**		**YES**	**NO**
High or Low Blood Pressure	[ ]	[ ]	Kidney Problems	[ ]	[ ]	Meningitis, Polio	[ ]	[ ]
Heart Attack (date_______)	[ ]	[ ]	Back Problems	[ ]	[ ]	Thyroid Disease	[ ]	[ ]
Stroke	[ ]	[ ]	Headaches	[ ]	[ ]	Anxiety Disorder	[ ]	[ ]
Irregular Heart Beat	[ ]	[ ]	Cancer	[ ]	[ ]	Diabetes or Hypoglycemia	[ ]	[ ]
Pacemaker	[ ]	[ ]	Ulcer / Hiatal Hernia	[ ]	[ ]	Hepatitis / Liver Problems	[ ]	[ ]
Chest Pain / Angina	[ ]	[ ]	Intestinal Disease	[ ]	[ ]	Sickle Cell Anemia	[ ]	[ ]
Congestive Heart Failure	[ ]	[ ]	Psychiatric Disorder	[ ]	[ ]	Immune Deficiency	[ ]	[ ]
Anemia	[ ]	[ ]	Epilepsy / Seizures	[ ]	[ ]	Aids / HIV	[ ]	[ ]
Bleeding Problems / Disorders	[ ]	[ ]	Dizziness	[ ]	[ ]	Blindness	[ ]	[ ]
Respiratory issues or disease	[ ]	[ ]	Arthritis	[ ]	[ ]	Deafness	[ ]	[ ]

Major illness not listed above: ______________________

List any major surgical procedures: ______________________

PLEASE CONTINUE FORM ON BACK SIDE

MEDICATIONS

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

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

Medication	Dosage / Regimen	Medication	Dosage / Regimen

FAMILY HISTORY

OCULAR	YES	NO
Blindness	[ ]	[ ]
Cataract	[ ]	[ ]
Glaucoma	[ ]	[ ]
Macular Degeneration	[ ]	[ ]
Retinal Detachment	[ ]	[ ]

MEDICAL	YES	NO
Diabetes	[ ]	[ ]
Arthritis, Lupus, Etc.	[ ]	[ ]

Other (list) ______________________

SOCIAL HISTORY

GENERAL	YES	NO	
Do you drink alcohol?	[ ]	[ ]	If yes, how much? ______________
Do you smoke?	[ ]	[ ]	If yes, how much? ______________
Have you ever smoked?	[ ]	[ ]	If yes, how much/long? ________ When did you quit? ________
Have you ever used illicit or Recreational Drugs?	[ ]	[ ]	If yes, what type? ______________
Have you had a blood transfusion?	[ ]	[ ]	If yes, when? ______________

DO YOU HAVE DIFFICULTY WITH ANY OF THE FOLLOWING?

	YES	NO
Feeling unsafe driving day or night due to glare?	[ ]	[ ]
Halos, star bursts, or glare from headlights at night?	[ ]	[ ]
Glasses that seem dirty even after cleaning 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?	[ ]	[ ]

	YES	NO
Seeing steps, stairs, or curbs?	[ ]	[ ]
Writing checks or filling out forms?	[ ]	[ ]
Playing games such as dominos or cards?	[ ]	[ ]
Reading small print on medicine bottles?	[ ]	[ ]
Looking at or reading recipes?	[ ]	[ ]
Watching television?	[ ]	[ ]
Night time driving?	[ ]	[ ]
Trouble adjusting to dark rooms after bright sunlight?	[ ]	[ ]

Other vision complaints:______________________________

GOALS FOR YOUR VISION

Are you interested in seeing well at a distance without glasses? [ ] Yes [ ] No

Are you interested in seeing up close (reading/needlework) without glasses? [ ] Yes [ ] No

What is/was your occupation? ______________________

What are your hobbies? ______________________

When are your glasses/contacts most bothersome?

[ ] Never
[ ] Boating/Fishing
[ ] Sports
[ ] Reading
[ ] Night time
[ ] Driving
[ ] Needlework (Sewing, knitting, crocheting)
[ ] Watching TV
[ ] Computer Work

What zone of vision is most critical to your lifestyle?

[ ] **Zone 1:** reading books and small print such as prescription bottles
[ ] **Zone 2:** computers, menus, reading large print
[ ] **Zone 3:** TV, cooking, board games
[ ] **Zone 4:** daytime driving, sports
[ ] **Zone 5:** night driving, movies, stargazing

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: