Layton Visual Center (801) 546-2481

79198

Guardian: ____ **Date:**

Name: ____

Address: ____

City, St: ____ **Zip:** ____

Phone(H): ____ **(C):** ____

Date of Birth: ____ **Sex:** ____

Vision or Primary Insurance

Ins.: ____ **#:** ____

Insured: ____ **DOB:** ____

Relationship:

Medical or Secondary Insurance

Ins.: ____ **#:** ____

Insured: ____ **DOB:** ____

Relationship:

E-Mail: ____

Notify me by: ☐ Text ☐ Phone ☐ Email ☐ Mail

Referred by (name of friend we can thank)

☐ Friend ☐ Insurance ☐ Phone Book ☐ Other...

Are you interested in Eyeglasses Today? ☐ Y ☐ N

Medical Doctor(s):

Approx. Date of Last Eye Exam with eye doctor: ____

Glasses R-

L-

Contacts R-

L-

Allergies

☐ NKDA
☐ Penicillin
☐ Sulfa
☐ Eye drops
☐ Seasonal
☐ Codeine

Current Medicines

History or Problems

☐ Allergy ☐ Eye Infection ☐ Macular Degen.
☐ Amblyopia ☐ Eye Injury ☐ Migraine
☐ Asthma ☐ Gastrointestinal ☐ MS
☐ Cataract ☐ Heart disease ☐ Psychological
☐ Crossed Eyes ☐ High B.P. ☐ Sinus
☐ Diabetes II ☐ Keratoconus ☐ Sinusitis
☐ Droopy Lid ☐ Kidney ☐ Thyroid
☐ Ear Problem ☐ Lazy Eye ☐ Other...

Eye wear History (have you ever worn...) Clear

☐ Glasses ☐ Soft Contacts ☐ Dailies ☐ Other...
☐ Bifocals ☐ Toric Soft ☐ Overnight wear
☐ Trifocals ☐ Gas Perm ☐ Mullti focal
☐ No- line ☐ Monovision ☐ Colored lenses

Family History (parents, grandparents, siblings)

☐ Blindness ☐ Kidney Disease ☐ High B.P. ☐ Other...
☐ Cataracts ☐ Macular Degen. ☐ Thyroid
☐ Crossed Eyes ☐ Retina Disease ☐ Glaucoma
☐ Color Blind ☐ Retina Detach ☐ Cancer
☐ Diabetes ☐ Heart Disease ☐ None

Current eye problem(s) (please circle the "main" problem)

☐ Blur at Far ☐ Eye strain ☐ Medical eye check
☐ Blur at Near ☐ Flashes/Floaters ☐ Annual/Routine
☐ Blur at Far & Near ☐ Loss of vision ☐ Other...
☐ Itching ☐ Double vision
☐ Burning ☐ Sandy/Gritty
☐ Redness ☐ Spots or shadows
☐ Eye pain ☐ Diabetes eye check

☐ Right eye ☐ Left eye ☐ Both eyes

☐ Mild ☐ Moderate ☐ Severe

☐ Started today ☐ 3-7 days ☐ 2-4 weeks ☐ 3-6 months
☐ 1-2 days ☐ 1-2 weeks ☐ 1-3 months ☐ Over 6 months

☐ Getting better ☐ Getting worse ☐ About the same

Are you interested in contact lenses information? Clear

☐ Try Contacts ☐ Upgrade Contacts ☐ No interest in Contacts

Optos Retinal Photo Exam:

No blurry vision or light sensitivity
Takes less than 2 minutes
Permanent digital image
No drops required
Dr. sees 80-90% inside of eye

Dilation:

Vision: Blurry 3-5 hours,
Light sensitive 2-3 hours
25 minute longer exam time
No permanent record of retina
Drops required
Dr. sees 50% inside of eye

I consent to the Retinal Photos for $29. (May be covered by insurance. Family discount available.) ☐ Y ☐ N

I consent to Dilation of the pupils. (Included in the comprehensive eye exam at no additional cost.) ☐ Y ☐ N

Our office requires payment at the time of service. **You are responsible for any and all charges that insurance does not cover. Contact lens fit and follow up care is billed separately from your eye exam which starts at $40.00.** Your information is protected by our privacy policy.

Remind me of my appointment by: ☐ Text

Signature____________________ Date__________

Relationship to Patient ____________________

Printed: DOB:

Signed