Kas Eye Center **Thank You & Welcome Back!**
www.kaseyecenter.com

Name: _____

Cell Phone: (_____)_____ **E-Mail:** _____ (EP)

WHAT IS THE REASON FOR TODAY'S VISIT? (Check all that apply)

☐ I have an **Eye Disease or Eye Problem** requiring examination: _____

☐ I want **Glasses**

☐ I am interested in a non-surgical way to see clearly (**Orthokeratology**). No glasses or contacts during the day and it helps your eyes from getting worse. (Good for ALL ages)

☐ I want **Contact Lenses:**
Rate 1-10 how happy you are with your contact lenses (Circle one) *not happy* 1-2-3-4-5-6-7-8-9-10 *very happy*

☐ I am here for my **Annual Eye Health** and **Vision Evaluation**

DO YOU EXPERIENCE ANY OF THE FOLLOWING? (Check all that apply)

☐ Distance vision blurred w/ glasses/contacts	☐ Dry/ Burning eyes	☐ See flashing lights
☐ Near vision blurred w/ glasses/contacts	☐ Watery eyes	☐ See floaters or spots
☐ Headaches related to eyes	☐ Itchy eyes	☐ Double Vision
☐ Eye strain	☐ Red eyes	☐ Sensitivity to lights

INSURANCE Has your VISION or MEDICAL insurance changed? ☐Y ☐N
Do you have a secondary vision insurance? ☐Y ☐N

Eligibility and verification of benefits does not guarantee payment. I understand that I am responsible for any unpaid claims or payments, including those applied to my annual deductible.

_____ _____
PATIENT SIGNATURE (If under 18, parent signature required) DATE

To our Contact Lens wearing Patients:

As is common in the eye care industry, we charge annual re-evaluation fees. The annual fee ranges from $59 - $79. If we need to change brands, then the re-fitting fee can be higher. This fee covers all contact lens follow-ups and any contact lens related eye problems for one year. Some vision plans will cover this fee in full or in part. As always, we will make every effort to honor your vision plans. Thank you for allowing us to provide the safest, most appropriate contact lenses for you and your family. Please let our staff know if you have questions or would like clarification.

I understand the above contact lens policy: _____ ***Thank You!***
initial

For Office Use Only:

CC/ROS
Happy with (GL / CL / VA)
Blurred Vision (OD/OS) (D/C/N) (GL/CL)
(M/Mod/Sev) (1/2/3/4/5/6 y/m/w/d)

Medical History No Meds/ No Allergy
Meds: BP/Chol/Diab/Om3/AT _____
Allergy: asp/cip/iod/pen/sul _____
Diab: act/ava/gli/glu/gly/ins/jan/met/tru/vic/xig
HBP: aml/asp/ate/car/coz/dio/fur/hyd/lis/los/lot/met/top
Chol: cre/lip/lov/pra/sim/vyt/zet/zoc **Thy**: lev **Arth**: hum/plaq **Asth:** alb/flo/sin ***All***: all/cla/flo/zyr **DES**: lot/res/xii

Vision (VF FDT ??)
WRx: (SVD /SVN /SVI /BF /TF /PALs)
OD 20/
OS 20/
Add
WRx: (SVD /SVN /SVI /BF /TF /PALs)
OD 20/
OS 20/
Add
VA (corr / uncorr) 20/
20/

Exam
Protocols: (1a /1h /1m /1p /2a.B /2a.L /2a.R /3b.B 4cmi.B /4cmo.B /4cs.B /5lll /5lul /5rll /5rul /6d.L 6d.R /6dno /7de /7dem /7demo /7des /8f.L /8f.R 9g.L /9g.R /9gs.at /9gsL /9gs.R /clfu /pvd.L /pvd.R re.all /re.B /re.bac.B /re.bac.L /re.bac.R /re.L /re.R re.vir.B /re.vir.L /re.vir.R

*IOL R / L . Larger Disc R / L
Discs OD 0. OS 0.