WELCOME

Patient Information Form

Dorit Scharff, OD and Jean Hsu, OD
Dodd Portman, OD, Inc

Last Name:_____ First_____ M.I____ Date:_____

Street Address:_____

City:_____ State:_____ ZIP:_____ Date of Birth:_____ Age:_____

Home No:_____ Cell No._____ Work No:_____

Email:_____

Place of Employment or School:_____ Type of work or Grade in School_____

Children's name and Ages_____ If child parent's names:_____

_____ Spouse's Name:_____

Preferred method of communication (E-mail, text, phone, etc):_____

Preferred language: English Spanish Hebrew Chinese Other_____

How did you hear about our office and who may we thank?_____

GENERAL INFORMATION

What is the main reason for today's visit?_____

Date of last eye exam?_____ Date of Last physical exam_____

Do you wear glasses? Yes No Do you wear sunglasses? Yes No

Do you wear contact lenses? Yes No

Have you ever worn contact lenses? Yes No

Are you interested in contact lenses for full time or occasional use? Yes No

Are you interested in Laser Vision Correction to reduce or eliminate the need for glasses or contacts? Yes No

Are you interested in learning about Myopia Control (slowing progression of near sightedness)? Yes No

How many hours do you spend on a computer each day? _____ Distance from screen_____

Do you experience any eye strain, headaches, or blurred vision while using a computer, or reading? Yes No

What activities/hobbies/sports do you enjoy? _____

(continued on next page)

Do you experience any of the following symptoms? Circle all that apply:

Blurred vision at distance	Blurred vision at near	Fluctuating vision	Dry eyes
Watery eyes	Red Eyes	Itchy Eyes	Light Sensitivity
Double Vision	Tired Eyes	Floaters or spots	Flashes of light
Headaches	Dizziness	Other _____	

MEDICAL HISTORY

Are you vaccinated against COVID 19? Yes No

List all current medications (prescription or non-prescription, including nutritional supplements)

_____

_____

Do you have any allergies or are you allergic to any medication?

Yes (please list)_____ No

Any history of _____smoking _____ Alcohol or substance abuse

Describe any current medical treatment (diabetes, hypertension, thyroid disease, pregnancy)

_____

Do you have a family history of any eye disease? (glaucoma, blindness, macular degeneration, color blindness, macular degeneration, cataracts, diabetic retinopathy, or other)

_____

Your Physicians Name:_____

Do you have vision insurance? Yes No Name of insurance company_____

Do you have medical insurance? Yes No Name of medical insurance_____

Preferred pharmacy (include address and phone) _____

_____

Our office policy is to receive payment at the time of service. If we are not on the panel of your insurance, we will be happy to assist you in filling out your insurance claim by giving you a SUPERBILL to submit for payment. Thank you!

We want to thank you for selecting our office for trusting us with your eye health and vision.
We strive to provide you with the best care possible.