UTAH VISION DEVELOPMENT CENTER

Welcome!

Patient Information

Name: _____ Today's Date: _____/_____/_____

Date of Birth: _____/_____/_____ Email: _____

Address: _____ Home Phone: _____

City, State, ZIP_____ Cell Phone: _____

Parent / Guardian:_____ Last Eye Exam: _____/_____/_____

Last Medical Exam: _____/_____/_____

Whom may we thank for referring you to our office?_____

Medical Insurance and Vision Plan Information

Medical Insurance:_____ Policy/ID #_____ Employer:_____

Name of Policy Holder_____ Date of Birth _____ Employer Phone # _____

Vision Insurance: _____ SSN/Policy ID #_____

Name of Policy Holder_____ Date of Birth _____ Relationship to Patient_____

Authorization & Release

Eye care services and products are recommended for your optimum eye health and vision needs. We will bill your medical insurance and/or vision plan for appropriate services and optical goods provided. There may be some items that your insurance does not cover. You are responsible for the remaining balance. The fact that your insurance company may not pay for a particular item or service does not mean you should not receive it. I acknowledge that I have had opportunity to review the office HIPAA policy. (*by signing below, you agree to the above statement*)

Financially responsible party_____ Employer_____

Printed Name_____ Employer phone #_____

Signature _____ Date_____

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Visual Symptoms Survey

Name _____

Date_____ Age_____

After you consider each question, mark the column that applies to the person you are assessing.

		NEVER	SELDOM	OCCASIONAL	FREQUENTLY	ALWAYS
Vision blurs when reading, writing, or working on computer	A	0	1	2	3	4
Headaches when reading, writing, or working on computer	A	0	1	2	3	4
Words go double or appear to move around when reading	B	0	1	2	3	4
Burning, itching or watery eyes when reading	A	0	1	2	3	4
Loses place when reading	OM	0	1	2	3	4
Tilts head or closes/covers one eye when reading	B	0	1	2	3	4
Difficulty copying from the whiteboard/chalkboard	A	0	1	2	3	4
Avoids near work such as reading or writing	B	0	1	2	3	4
Skips over or leaves out small words when reading	OM	0	1	2	3	4
Writes uphill or downhill; difficulty writing in a straight line	O	0	1	2	3	4
Difficulty lining up numbers when doing math	OM	0	1	2	3	4
Difficulty understanding what you read / poor comprehension	P	0	1	2	3	4
Holds books too close; leans too close to computer screen	A	0	1	2	3	4
Difficulty keeping attention on reading material	B	0	1	2	3	4
Difficulty finishing assignments on time	P	0	1	2	3	4
First response is "I can't" before trying	P	0	1	2	3	4
Clumsy, bumps into things, knocks things over	O	0	1	2	3	4
Does not use time well when doing near work (homework)	P	0	1	2	3	4
Loses belongings and things	P	0	1	2	3	4
Forgetful, poor memory	P	0	1	2	3	4
	Totals					

20-24 points = suspect **25 or more = refer for care** **Total Score =**

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