VISION SOURCE™

Lake Oswego

Dr. Stephen Olsen & Associates

Optometrists

Welcome To Our Office

Name:		**Date:**
Address:	**City, State, Zip:**	
Primary Phone: ☐ Mobile	**Other Phone:** ☐ Mobile	**Email:**
Date of Birth:	**Social Security#** (Last 4 digits only):	**Communication Preference:** ☐ Phone ☐ Email ☐ Text ☐ Postal
Employer:	**Occupation:**	
Work Phone: ☐ Mobile	**Height:**	**Weight:**

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Decline to share

Race: ☐ Caucasian ☐ Black/African American ☐ Asian ☐ Hawaiian/Pacific Islander ☐ Other _____

Insurance Information

Medical Insurance Company Name:			**Vision Insurance Company Name:**	
ID#:	**Group#:**		**ID#:**	**Group#:**
Primary Subscriber (if different from patient):			**Primary Subscriber (if different from patient):**	
Relationship: ☐ **Spouse** ☐ **Parent** ☐ **Other**			**Relationship:** ☐ **Spouse** ☐ **Parent** ☐ **Other**	

I, the undersigned, have insurance coverage with _____and assign directly to Dr. _____ all medical and/or vision benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature: _____ **Date:** _____

(Please turn over and complete other side)

Medical and Visual History

Please circle all that apply:

Diabetes: Self Family history Relationship_____

High Blood Pressure: Self Family history Relationship_____

High Cholesterol: Self Family history Relationship_____

Cataracts: Self Family history Relationship_____

Glaucoma: Self Family history Relationship_____

Macular Degeneration: Self Family history Relationship_____

Thyroid: Self Family history Relationship _____

Cancer: Self Type: _____

Asthma Self

Allergies: To medications: _____ Other: _____

Frequent Headaches? Yes / No If yes, please describe: _____

Do you smoke? Yes / No

Pregnant/Nursing? Yes / No

Current prescription medications: _____

_____

Current over-the-counter medications: _____

_____

Date of last vision examination: _____ **Examining Doctor:** _____

Currently wear glasses? ☐Full time ☐Part time		**For:** ☐ Distance ☐ Near ☐Both	
Wear contact lenses? ☐Full time ☐Part time		**For:** ☐ Distance ☐ Near ☐Both	
	☐ Soft ☐ Toric ☐ Bifocal ☐ Rigid ☐ Disposable	☐ Daily Wear ☐ Extended Wear	
	Daily wearing time:	Replacement Schedule:	Disinfection Solution:

Any special visual tasks (computer, sports, outdoors, etc.): _____

Reason for today's appointment: _____

Who may we thank for referring you? _____