ADVANCED EYECARE CENTER

Rebecca V. St.Jean, O.D.
Dr. Elicia Miller, O.D.
4030 MacCorkle Ave. SW
South Charleston, WV 25309
Advanced-eyecare.com
304-766-2220

Welcome to Our Office

Name_____
Street_____
City_____ State____ Zip_____
Home phone_____
Work phone_____
Date of birth_____ Age_____ Sex: M☐ F☐
Marital Status: Single☐ Married☐
Divorced☐ Widowed☐
Social security number_____
Employer_____
Occupation_____
Hobbies_____
Email address_____

Date of last eye exam_____
Vision Insurance Company_____
Spouse's name (if you are insured under their plan)_____
Social Security # of insured_____

Personal & Family Medical History

Allergies	☐No☐Yes	Glaucoma	☐No☐Yes
Asthma	☐No☐Yes	Eye diseases	☐No☐Yes
Arthritis	☐No☐Yes	Heart disease	☐No☐Yes
Cancer	☐No☐Yes	Eye injury	☐No☐Yes
Eye surgery	☐No☐Yes	High Blood pressure	☐No☐Yes
Diabetes	☐No☐Yes		

Are you currently under the care of a physician? ☐No☐Yes
Name of physician_____

Current Medications (Rx & Over-the-Counter)

Please list:

_____
_____
_____
_____
_____

How did you hear about our office?
☐ Friend or relative. Who?_____
☐ Newspaper, yellow pages, radio advertisement? (circle)
☐ Other_____

How will you settle your account today?

☐Check ☐Cash ☐Credit Card ☐Payment Plan

Diagnostic Issues

Please list any complaints about wearing glasses or contacts?

_____
_____
_____
_____

- Do you have more than one pair of current Rx glasses? ☐No ☐Yes
- Do you work on a computer for long periods of time? ☐No ☐Yes
- If you wear glasses, would you benefit from thinner, lighter lenses? ☐No ☐Yes
- Do you spend a lot of time outdoors? ☐No ☐Yes
- If you wear bifocals, are you bothered by restricted windows, lines or head tilting? ☐No ☐Yes
- Are there times you'd rather not wear glasses? ☐No ☐Yes
- If you wear contact lenses, are you satisfied with the vision and comfort? ☐No ☐Yes
- Are you interested in a "test drive" of the latest in contact lens design(s)? ☐No ☐Yes
- Laser vision correction is a common choice to reduce or eliminate the need for glasses or contacts. Do you desire information regarding laser vision correction and /or a free evaluation regarding you candidacy? ☐No ☐Yes

Do You Experience....

Any discomfort with your eyes?	☐No ☐Yes
Problems with glare or reflection?	☐No ☐Yes
Sensitivity to light?	☐No ☐Yes
Headaches?	☐No ☐Yes
Floaters or flashes of light?	☐No ☐Yes

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Welcome Back to Our Office

Please review the information on the reverse side to determine if there have been any changes in information since your last visit.

Date:_____

Personal Information
(Address, phone #'s, ins. Co., etc)

Changes:

Medications or Health History

Changes:

Diagnostic Issues

Do you have any problems with present glasses or contacts?

- Do you have more than one pair of current Rx glasses? ☐No ☐Yes
- Do you work on a computer for long periods of time? ☐No ☐Yes
- If you wear glasses, would you benefit from thinner, lighter lenses? ☐No ☐Yes
- Do you spend a lot of time outdoors? ☐No ☐Yes
- If you wear bifocals, are you bothered by restricted windows, lines or head tilting? ☐No ☐Yes
- Are there times you'd rather not wear glasses? ☐No ☐Yes
- If you wear contact lenses, are you satisfied with the vision and comfort? ☐No ☐Yes
- Are you interested in a "test drive" of the latest in contact lens design(s)? ☐No ☐Yes

Date:_____

Personal Information
(Address, phone #'s, ins. Co., etc)

Changes:

Medications or Health History

Changes:

Diagnostic Issues

Do you have any problems with present glasses or contacts?

- Do you have more than one pair of current Rx glasses? ☐No ☐Yes
- Do you work on a computer for long periods of time? ☐No ☐Yes
- If you wear glasses, would you benefit from thinner, lighter lenses? ☐No ☐Yes
- Do you spend a lot of time outdoors? ☐No ☐Yes
- If you wear bifocals, are you bothered by restricted windows, lines or head tilting? ☐No ☐Yes
- Are there times you'd rather not wear glasses? ☐No ☐Yes
- If you wear contact lenses, are you satisfied with the vision and comfort? ☐No ☐Yes
- Are you interested in a "test drive" of the latest in contact lens design(s)? ☐No ☐Yes