**BEAVERTON VISION WORLD** **TIGARD VISION WORLD**

www.bvweyes.com www.tvweyes.com

**Today's Date:**_____

**Patient Information:**

Last Name:_____ First:_____ MI._____

Address:_____

City:_____State:_____Zip Code:_____

Home Phone:(_____)_____ Work Phone: (_____)_____

Cell Phone: (_____)_____ Email: _____

*Your email is only used to send you reminders, prescriptions and itemized receipts, at your request.*

Gender: ☐ Male ☐ Female Date of Birth: _____/_____/_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Occupation: _____ Employer: _____

**Responsible Party (If different from above)**

Last Name:_____ First: _____

Relationship to Patient: _____ Gender: ☐ Male ☐ Female

Home Phone: (_____)_____ Cell Phone: (_____)_____

**Emergency Contact:**

Name:_____ Relationship: _____

Address: _____

Home Phone: (_____)_____ Cell Phone: (_____)_____

**Warranty Policy: IMPORTANT! Please read and initial at each line.**

_____ 1. Beaverton/Tigard Vision World honors all manufacturers' warranties on frames and lenses. This does NOT cover abuse, neglect, accidental damage/destruction, or loss. Warranty frame replacements are subject to a $15 shipping & handling fee.

_____ 2. The patient has 90 days from the completion of an order to request prescription or lens changes. If replacing with a less expensive product, the patient will not be refunded the difference.

_____ 3. Patients' own frame will be fitted with lenses at the patients' risk. Beaverton/Tigard Vision World and our associated lab partners are not responsible for breakage due to age, wear and tear, or defects.

_____ 4. Prescription eyewear is a custom made product. Sales of completed eyewear are final. Any alterations or changes fall under the above 90 day policy.

**If you have any questions about our warranty policy, please ask!**

We appreciate your business! Estimated time of delivery is **between 7 and 10 *business days***.

Customer Signature:_____ Date: _____

**Health History:**

Reason for today's exam: _____

Does anyone in your immediate family have a history of the following? Please list how they are related and circle whether they are on your maternal or paternal side of the family.

- ☐ Cataracts _____Mat./Pat.? ☐ Diabetes _____ Mat./Pat.?
- ☐ Glaucoma _____Mat./Pat.? ☐ High Blood Pressure _____ Mat./Pat.?
- ☐ Retinal detachment _____ Mat./Pat.?
- ☐ Macular degeneration _____ Mat./Pat.?

Please check if any of the following conditions apply to you:

- ☐ Frequent Headaches ☐ Sinus trouble ☐ Pregnant ☐ Given birth in last 6 months
- ☐ Floaters ☐ Sensitive to light ☐ Eye strain ☐ Eyes burn/itch
- ☐ Medication allergies, please list: _____
- ☐ Other Allergies, please list: _____

Do you have a history of problems with the following:

- ☐ Diabetes; type? _____ Date of diagnosis: _____
- ☐ Heart Condition ☐ High Blood Pressure ☐ Thyroid condition ☐ Respiratory
- ☐ Cataracts ☐ Glaucoma ☐ Mental Health ☐ Retinal detachment
- ☐ Macular Degeneration ☐ Elevated cholesterol

Any other health problems not included above: _____

_____

Please list all medications you are currently taking: _____

_____If none, check: ☐

Surgeries: ☐ Yes ☐ No If yes, what kind: _____When: _____

Name of Primary Care Physician: _____

Location: _____ Telephone: (_____)_____ Date of last visit: _____

Do you currently wear glasses: ☐ Yes ☐ No

If yes, when do you wear your glasses?

- ☐ All the time ☐ Reading/near work
- ☐ Work safety ☐ Distance tasks only (driving, etc.)
- ☐ Computer work ☐ Other, please explain: _____

Have you ever worn contacts? ☐ Yes ☐ No

Are you interested in wearing contact lenses? ☐ Yes ☐ No

Do you work at a computer? ☐ Yes ☐ No

Could you benefit from prescription sunglasses? ☐ Yes ☐ No

Do you smoke or use tobacco products? ☐ Yes ☐ No