



Dr. Daniel W. Pace

Dr. Adam B. Rudd

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Today's Date: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  Male  Female  
Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_  
Address: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Texting Ok   
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Occupation: \_\_\_\_\_ E-Mail: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_

Who May We Thank for Referring You to Our Office: \_\_\_\_\_

Family Members at your residence:

Name: \_\_\_\_\_ age: \_\_\_\_\_ Name: \_\_\_\_\_ age: \_\_\_\_\_  
Name: \_\_\_\_\_ age: \_\_\_\_\_ Name: \_\_\_\_\_ age: \_\_\_\_\_  
Name: \_\_\_\_\_ age: \_\_\_\_\_ Name: \_\_\_\_\_ age: \_\_\_\_\_

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**Insurance Information...** Please provide your card to the front desk and the following info on the Policy Holder:

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Last 4 of SSN: \_\_\_\_\_

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**What is the Primary Reason for Your Visit to Our Office Today:** \_\_\_\_\_

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**Are You Interested In:** (Circle all that apply)

Contact Lenses	Bifocal Contact Lenses	Rx Sunglasses	No-Line Bifocals	UV Protection
Anti-Glare Lenses	Computer Specific Rx	Sports Eyewear	Safety Eyewear	Lasik Surgery

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### Eye / Visual History

Date of Last Eye Exam: \_\_\_\_\_ Where: \_\_\_\_\_

Do You Wear Glasses?  Yes  No If yes, when:  Full Time  Distance  Near

Do you Wear Contacts?  Yes  No What type?  Soft  Gas Permeable  Toric  Bifocal

Do you have (or have you ever had) any of the following eye or vision problems? (Circle all that apply)

Blurry Vision	Eye Infections	Flashes of Light	Itchy Eyes
Crossed or Lazy Eye	Eye Injuries	Floaters in Vision	Sensitivity to Light
Double Vision	Eye Surgery	Headaches	Tired / Irritated Eyes

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## Personal Medical History

How Would You Rate Your Health in General?     Excellent     Good     Fair     Poor

Date of Last Medical Exam \_\_\_\_\_ Name of Family Doctor \_\_\_\_\_

Please List All Medications You Are Taking \_\_\_\_\_

Do You Have Any Allergies?     Seasonal     Sulfa     Penicillin     Others \_\_\_\_\_

Do You Use Tobacco?     Yes     No            Alcohol?     Yes     No

Do You Have Any Problems with Any of These Body Systems? (Circle Any That Apply)

Gastrointestinal	Nervous	Psychiatric	Ears / Nose / Throat
Genitourinary	Blood / Lymph	Endocrine (glands)	Cardiovascular
Musculoskeletal	Integumentary (skin)	Respiratory	Immunologic (allergic)

Please Explain any "Yes" Answers \_\_\_\_\_

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## Family History

Does Your Family Have a History of the Following Problems?

Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No
High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Retinal Detachment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cataracts	<input type="checkbox"/> Yes <input type="checkbox"/> No
Vision Loss	<input type="checkbox"/> Yes <input type="checkbox"/> No	Macular Degeneration	<input type="checkbox"/> Yes <input type="checkbox"/> No

Other Eye or Medical Conditions? \_\_\_\_\_

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I certify that I have read, understand, and have accurately answered the above information to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I understand that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. I authorize and request my insurance company to pay directly to the eye doctor insurance benefits otherwise payable to me. I understand that I am financially responsible for all charges whether or not paid by said insurance. I authorize the eye doctor to release any information including the diagnosis, records of any treatment or examination rendered to me or my child during the period of such eye care to third party payers and / or health practitioners. In the event that full payment for charges is not made, I agree to pay all cost of collections, Collection Agency commission, attorney's fees, and interest. I also agree to submit myself to the jurisdiction of the courts of Utah.

Signed by Patient (or Parent if Minor) \_\_\_\_\_ Date: \_\_\_\_\_