

# Welcome Back



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

Date: \_\_\_\_\_

Email: \_\_\_\_\_

Mobile Phone: \_\_\_\_\_

Did you receive an email or text reminder for your appointment? Yes or No

Do you have any new medical conditions or new medication? Yes or No

If so, what: \_\_\_\_\_

Reconfirm Insurance- Give **all insurance cards** to our staff and reconfirm which insurance you will be using:

Primary: \_\_\_\_\_

Secondary: \_\_\_\_\_

**IMPORTANT!! To better care for you today, please tell us the following information-**

<p><b>What problem(s) or concern(s) brings you see the eye doctor today?</b></p>	<p><input type="checkbox"/> Glaucoma <input type="checkbox"/> Cataracts <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Diabetes  <input type="checkbox"/> Dry Eyes <input type="checkbox"/> Irritated or pink eyes <input type="checkbox"/> Macular Degeneration  <input type="checkbox"/> Floaters/Flashes <input type="checkbox"/> Pain <input type="checkbox"/> Itching <input type="checkbox"/> Injury <input type="checkbox"/> Previous Surgery  <input type="checkbox"/> Follow Up <input type="checkbox"/> Other: _____</p>
<p><b>What change(s) have you noticed with your eye(s) since your last exam?</b></p>	<p>_____</p>
<p><b>What medication(s) or vitamin(s) do you take specifically for your eyes? How often do you use these products?</b></p>	<p>_____</p>
<p><b>How would you like to improve your glasses?</b></p>	<p><input type="checkbox"/> Scratched Lenses <input type="checkbox"/> Less Glare <input type="checkbox"/> Better vision on computer  <input type="checkbox"/> Better Driving Vision <input type="checkbox"/> New Frame Style <input type="checkbox"/> Thinner Lenses  <input type="checkbox"/> Other: _____</p>
<p><b>What other information should we know to better care for you today?</b></p>	<p>_____</p>

**How can we improve upon your visit today versus previous visits at West Tennessee Eye?**

(Understanding of condition, understanding of treatment, wait time, cleanliness of office, friendliness of staff, time with doctor, issues with glasses, issues with contact lens, or other concerns)

**Which family members have not seen an eye specialist for a comprehensive exam this year?**

(This does not include school screenings or pediatrician screenings, which are not comprehensive exams.)

- Spouse / Partner       School aged children       Parents