Dear Patient,

Welcome to The Eyeglass Shop! We are so glad you have chosen our practice for your family's comprehensive eye care. We want you to be confident that you will receive premium care to sustain both your vision and the health of your eyes.

Your exam will include:

- A comfortable, personalized, and comprehensive eye exam with easy to understand information. We ask that you **please bring in all of the eyeglasses and sunglasses that you currently wear** so that the prescriptions can be compared to your new prescription. This will help Dr. Aaker determine how your eyes are changing. Most of our patients do not require a pupil dilation; however, Dr. Aaker will determine if a dilation is necessary to properly evaluate the health of your eyes during your exam. A visual analysis will be performed to determine the state of your eyes and investigate any signs of disease or other eye health problems that may not have visible symptoms.

- We strive to spend quality time with each and every patient, and proper communication insures us this ability. If it is necessary to reschedule your reservation for any reason, please give us a call as soon as possible at (210) 828-1321 and we would be happy to do this for you.

- We have an excellent selection of eyewear frames, which includes some of the most desired name brands, such as Silhouette, Lindberg, Gucci, Ray Ban, Calvin Klein, Nike, Adidas and many more. You are encouraged to arrive early to have one of our opticians help you select the right frames for you. You can trust us with a customized premium fitting for the visual demands of your lifestyle including sunwear, progressives (no-line), and eyewear specific to your hobbies and work. We feature an exclusive **2 Year Eyewear Warranty** to assure you of the quality of our products and our commitment to your complete satisfaction.

- If you are a contact lens wearer or are interested in wearing them, **Dr. Aaker will perform a contact lens evaluation for a fee in addition to your eye exam.** Dr. Aaker specializes in difficult fits for any age including high astigmatism, bifocal, monovision, and patients who have been unable to wear contact lenses in the past. The Eyeglass Shop features a topographer which takes a detailed map of the cornea (clear tissue on which the contact lens fits) to ensure the highest level of health, comfort, and vision with contact lens wear. All contact lens evaluations include a topography, contact lens ocular health evaluation with the slit lamp microscope, visual analysis by Dr. Aaker, diagnostic starter lenses, insertion and removal training, and any necessary follow up care. Combined with our exclusive **Contact Lens Buy 'Em Back Guarantee**, we deliver an exceptional contact lens experience. **If you currently wear contact lenses, please bring the current specifications (located on your contact lens boxes).**

As a courtesy, our team will research your eye care benefits prior to your appointment. **Please bring your insurance card with you at the time of your visit.** Our goal is to keep you seeing your best, while improving your eye health and maximizing any insurance benefit. In order for us to provide the best possible office experience, **please complete the enclosed Welcome Form and bring it to your appointment.** This diagnostic information helps Dr. Aaker determine your specific needs and aids in developing your treatment plan and recommendations year after year.

Please plan on arriving approximately 15 minutes ahead of schedule, as there are tests that we will need to perform *before* your appointment time with Dr. Aaker.

Again, thank you for choosing The Eyeglass Shop. The greatest compliment you can give us is to refer your friends, coworkers, and family to our practice. Please do not hesitate to let us know how we can serve you better. We look forward to seeing you soon!

Dr. Aaker and The Eyeglass Shop

2526 Nacogdoches Road
San Antonio, TX 78217
(210) 828-1321

Welcome to The Eyeglass Shop

Name (First, M.I., Last): _____ Preferred Name: _____

How would you like us to address you? (First/preferred name, Mr., Mrs., Dr., Miss, etc) _____ Gender: M / F Birth Date: _____

Social Security Number: _____ What is your occupation and employer/school?_____

Home Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____ E-mail address: _____

Marital Status: □ Single □ Married □ _____ Referred by: _____

We must have a copy of all insurance cards on the day of service

Primary Medical Insurance: _____ Secondary Medical Insurance: _____

Vision Insurance: _____ Insured's Name: _____ Insured's Social Security Number: _____

Insured's Birth Date: _____ Insured's Employer: _____

Family Doctor: _____ Family Dr. Clinic/Phone: _____

Family Members: _____ For ease of data transfer, please circle their names if they are patients at this office.

NOTICE OF PRIVACY PRACTICES: I have been offered a copy of The Eyeglass Shop's statement on privacy practices.
AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize The Eyeglass Shop to release any medical or incidental information that may be necessary for medical benefit or in processing applications for financial benefit. This includes but is not limited to my insurance company, other health care providers, Rehabilitation Services, Social Security Administration, and Worker's Compensation.
CONSENT FOR TREATMENT: I hereby authorize The Eyeglass Shop to administer diagnostic and medical procedures as may be necessary for proper health care.
OFFICE POLICY ON PAYMENT: I understand that I am responsible for payment of all charges. As a courtesy, my insurance will be billed for me. It is my responsibility to pay any deductible, copay or any other balance not paid by my insurance company. I authorize insurance benefits to be paid directly to the provider.
VISION PLAN COVERAGE: I understand that only one vision plan may be used for exam/materials per visit-per patient and that the vision plan to be used must be chosen before the exam occurs and cannot change at a later date

SIGNATURE (patient, parent or legal guardian): _____ DATE: _____

REASON FOR TODAY'S EXAM: _____

Approximate Date of Last Eye Exam: _____ Name of Office and/or Eye Doctor: _____

Are you experiencing any of the following?

□ **Changes in vision with current glasses**	□ **Glare**	□ **Dryness/Burning**	□ **Sandy/gritty feeling**
□ **Changes in vision with current contact lenses**	□ **Light sensitivity**	□ **Watery eyes**	□ **Red eyes**
□ **Blurred vision**	□ **Tired eyes or eye strain**	□ **Itchy eyes**	□ **Other (explain):**

YOUR OCULAR HISTORY

Have you been diagnosed with or had any of the following (check all that apply):

□ **Dry Eyes** □ **Eye Allergies** □ **Infection Due to Contact Lenses** □ **Cataracts** □ **Glaucoma** □ **Macular degeneration** □ **Amblyopia or "Lazy Eye"**
□ **Strabismus (Eye Turn or "Lazy Eye")** □ **Blindness** □ **Retinal Problems** □ **Eye Surgery:** _____
□ **Other Eye Disease:** _____

YOUR MEDICAL HISTORY

Have you been diagnosed with or had any of the following (check all that apply):

□ **Diabetes** □ **High Blood Pressure** □ **High Cholesterol** □ **Heart Disease** □ **Stroke** □ **Brain Tumor** □ **Environmental Allergies**
□ **Hypo/Hyperthyroidism** □ **Sjogren's Syndrome** □ **Rheumatoid Arthritis** □ **Crohn's Disease** □ **Ulcerative Colitis** □ **Lupus**
□ **Ankylosing Spondylitis** □ **Cancer** □ **Multiple Sclerosis** □ **Mental Health Condition:** _____ □ **Other:** _____

FAMILY HISTORY

To your knowledge, have any of your blood relatives been diagnosed with any of the following (check all that apply):

□ **Diabetes** □ **Cataracts** □ **Glaucoma** □ **Macular degeneration** □ **Amblyopia or "Lazy Eye"**
□ **Strabismus (eye turn or "Lazy Eye")** □ **Blindness** □ **Retinal Problems** □ **Other Eye Disease:** _____

CURRENT VISION

Glasses: How many pairs of prescription eyewear do you currently use? _____
What type of lenses are in your **primary** pair of eyewear? ☐ **Single vision** ☐ **Bifocal** ☐ **Trifocal** ☐ **No-line (Progressive)** ☐ **N/A**
Are you planning on purchasing Visionary Eyewear or Sunwear today? ☐ **Y** ☐ **N** ☐ **Maybe**
What type of Visionary Eyewear are you interested in? ☐ **All Purpose** ☐ **All Purpose Progressive** ☐ **Prescription Polarized Sunwear**
☐ **Non-Prescription Sunwear** ☐ **Computer** ☐ **Reading** ☐ **Golf** ☐ **Fishing** ☐ **TV/Distance only** ☐ **Safety** ☐ **Sports**

Contact Lenses: Do you currently wear contact lenses? ☐ **Y** ☐ **N** If yes, how would you rate your current contact lens wearing experience from 1-10? _____
If not a 10, what could be improved? ☐ **Comfort** ☐ **Convenience** ☐ **Clarity of Vision** ☐ **Other:** _____
Are you interested in wearing or continuing to wear contact lenses? ☐ **Y** ☐ **N** ☐ **Maybe**
For what purpose would you like to wear your contact lenses? ☐ **As much as is healthy and safe for my eyes** ☐ **Work/School** ☐ **Sports/Working Out**
☐ **Evening Wear** ☐ **Pool/Water Sports** ☐ **Firearms/Hunting**

What is the manufacturer/brand of your contact lenses? _____ What are the powers of your contact lenses (if you know)? _____
How old are your current contact lenses? _____ How often do you replace your contact lenses? _____
What solutions do you use to care for your contact lenses? ☐ **Biotrue** ☐ **Opti-Free PureMoist** ☐ **Clear Care** ☐ **Other:** _____

Are you a current or former smoker?
☐ **Y** ☐ **N**
Are your eyes sensitive to sunlight?
☐ **Y** ☐ **N**
Problems with reflections and/or glare?
☐ **Y** ☐ **N**
Are you interested in changing your eye color (subtle/natural or vibrant changes available)?
☐ **Y** ☐ **N** ☐ **Maybe**
Do you have any children?
☐ **Y** ☐ **N**
Hours of daily computer use: _____

Please list your sporting activities/hobbies: _____

List any known allergies to medicine: _____