ULLA EYEWEAR

DATE: _____/_____/_____

Patient Information

Last name: _____ **First name**: _____ ☐**M or** ☐**F**

Name Preference: _____ **DOB:** _____/_____/_____ **Last 4 of SSN:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Ph: (_____)_____-_____ **Cell Ph:** (_____)_____-_____ **Work Ph:** (_____)_____-_____

Which number is your preferred contact number? ☐**H** ☐**C** ☐**W**

Email: _____ **Communication Preference:** ☐**Text /** ☐**Email**

Race: _____ **Preferred Language:** _____

Employer and Occupation: _____

Date/Location of last eye exam: _____ **Primary Care Physician:** _____

How did you hear about our new doctor? _____

Vision Insurance: _____ **ID#:** _____

Primary Insurance Holder's Name: _____ **DOB:** _____/_____/_____

Primary Insurance Holder's Last 4 of SSN: _____

Relationship to Patient: Self / Spouse / Parent

Medical Insurance: _____ **ID#:** _____

Primary Insurance Holder's Name: _____ **DOB:** _____/_____/_____

Primary Insurance Holder's Last 4 of SSN: _____

Relationship to Patient: ☐Self /☐Spouse / ☐Parent

Do you currently wear glasses?☐**Y** or☐**N** **Are you happy with your vision currently?**☐**Y** or☐**N**

Do you wear contact lenses?☐**Y** or☐**N** or☐**INTERESTED**

If you currently wear contact lenses, are you happy with the vision and comfort?☐**Y** or ☐**N**

Do you experience any of the following?

□ **Dry eyes** □ **Computer related eyestrain** □ **Halos while driving at night** □ **Sensitivity to light**

□ **Other** _____

Please contact us with any questions Ph: 608.231.3937 or E: foryou@ullaeyewear.com

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DATE: _____/_____/_____

Do you use tobacco products?☐Y or☐N If Yes Type _____ Amount _____ How Long _____

Do you drink alcohol? ☐Y or☐N If Yes Type _____ Amount _____ How Long _____

Please Check any of the following activities you engage in:

☐Golf ☐Music ☐Bicycle ☐Home ☐Workshop ☐Bowling ☐Fishing ☐Swimming ☐Cooking

☐Sewing ☐Ski ☐Hunting ☐Painting ☐Needlework ☐Flying ☐Photography

Other Hobbies or interests that have specific vision requirements? _____

Medical	**Self**	**Medications – List Names**	**Relative – List Relationship**
Diabetes			
High Blood Pressure			
Cholesterol			
Heart Disease			
Thyroid			
Arthritis			
Cancer (type)			
Asthma			
Behavioral/Psychiatric			
HIV/AIDS			
Herpes/Shingles			
Headaches/Seizures			
Allergies to Medication			
Other Not Listed			

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Ocular	Self	Medications – List Names	Relative – List Relationship
Glaucoma			
Dry Eye			
Retinal Disease			
Macular Degeneration			
Eye Surgery			
Eye Injury			
Eye Allergies			
Blurred/Double Vision			
Cataracts			
Other Not Listed			

Thank you for choosing Ulla Eyewear for all your eyewear needs. To ensure the privacy, respect and courtesy to our patients, we enforce the following acknowledgements and policies. Please do not hesitate if you have any questions.

Initials

	Payments of co-pays, deductibles or any balances not covered by insurance are due at the time of service
	We accept payment by cash, Visa, Mastercard, American Express, Discover and Care Credit. We unfortunately do not accept checks.
	Please silence your cell phone during the exam. Selfies are welcome while trying on frames ☺
	We value your time. We try our very best to stay on schedule, although emergencies sometimes arise
	If you are unable to make your appointment for any reason please let us know right away so we can reschedule your exam. There is a $25 no show/same day cancellation fee.
	Our exam includes dilation to detect eye disease. Dilation eye drops will last approximately 1-4 hours. You will experience sensitivity to light and blurry near vision. If you did not bring dark glasses we will provide you with a disposable pair.

I understand that I am responsible for any balance not paid by insurance.

Signed: _____ Date: _____/_____/_____

Please contact us with any questions Ph: 608.231.3937 or E: foryou@ullaeyewear.com