Welcome to Our Office !

(PLEASE PRINT - Please understand that the following information is required by your insurance company) Date _____

Name _____ Date of Birth _____ Age _____ Sex: M ___ F ____

Address _____ Drivers License # _____

City _____ State _____ Zip _____ Spouse or Parents Name _____

Home Phone (_____)_____ Family Members_____

Work (_____)_____ Guarantor of Payment _____Phone _____

Employer (or School) _____ Date of Last Eye Exam _____ Doctor/City _____

Occupation (or Grade in school) _____ Medical Insurance _____Vision Insurance_____

Do you have a Flex Spending Plan? Y / N

HOW DID YOU FIRST HEAR ABOUT OUR OFFICE?

- ☐ Referred by a friend or relative
  If so, whom may we thank?_____
- ☐ Referred by a health care practitioner or teacher
  If so , whom may we thank? _____
- ☐ Yellow Pages ☐ Office sign
- ☐ Other _____

We are making greater use of e-mail to communicate with our patients. To help us provide prompt service, please provide your e-mail address below (we do not sell or share this information):

_____

WHAT IS THE MAIN PURPOSE OF THIS VISIT?

_____

Do you have any concerns with your present contacts or eyeglasses?

_____

How old are your present Contact Lenses _____ Eyeglasses _____

Type of contacts worn (please circle):

• Soft Disposable • Extended Wear • Myopia Control •
• OrthoKeratology • Rigid Gas Permeable • Hard •

Do you have an interest in contact lenses?..... Y / N

Do you have an interest in Laser Vision Correction?... Y / N

DO YOU HAVE ANY OF THE FOLLOWING EYE RELATED CONDITIONS?

GENERAL EYE CONDITIONS

Blurry distance vision..... Y / N
Blurry reading or near vision..... Y / N
Computer related eye strain or headaches..... Y / N
Double Vision..... Y / N

EYE HEALTH CONDITIONS

Amblyopia / Lazy eye ..... Y / N _____
Cataracts ..... Y / N _____
Dry Eyes..... Y / N _____
Eye discharge ..... Y / N _____
Eye Injury ..... Y / N _____
Eye Pain..... Y / N _____
Eye Surgery ..... Y / N _____
Glaucoma ..... Y / N _____
Itchy scratchy eyes..... Y / N _____
Macular Degeneration..... Y / N _____
Redness..... Y / N _____
Retinal Detachment..... Y / N _____
Spots or Floaters ..... Y / N _____
Other _____

CURRENT MEDICATIONS (Either Rx or Over the Counter)

	Medication
Diabetes Meds or injections... Y / N	_____
High Blood Pressure Meds..... Y / N	_____
Oral Contraceptives ..... Y / N	_____
OTC Eye Drops or Eye Meds. Y / N	_____
Other..... Y / N	_____
Currently under a physicians care?.....Y / N	Purpose_____
	_____

Please circle any family history for the following eye conditions
(Please note if parent, grand parent, sibling etc.)

	Relationship to Patient
Amblyopia/Lazy Eye... Y / N	_____
Blindness.....Y / N	_____
Cataracts.....Y / N	_____
Glaucoma.....Y / N	_____
Macular Degen.....Y / N	_____
Retinal Detach.....Y / N	_____
Other..... Y / N	_____

(OVER)

✳ ***THIS INFORMATION IS STRICTLY CONFIDENTIAL!*** You may discuss this portion with the doctor if you prefer ✳

SOCIAL HISTORY

Tobacco products, do you use them?..... Y / N If yes, type / amount / how long:_____

Alcohol products, do you use them?..... Y / N If yes, type / amount / how long: _____

Have you ever been exposed to or infected with: ☐ Hepatitis ☐ HIV ☐ Gonorrhea ☐ Syphilis ☐ No

REVIEW OF MEDICAL SYSTEMS

List the medications you are taking: _____

List the medications you have allergies to: _____

Are you pregnant/nursing? Y / N Due Date: _____

Medical History - please check those that apply:

☐ Allergic / Immunologic (Sesonal, meds, lupus, rheumatoid arthritis)
☐ Cardiovascular (hypertension, heart disease, stroke, etc.)
☐ Ears, Nose, Mouth, Throat (URTI)
☐ Endocrine (diabetes, thyroid dysfunction, hormonal dysfunction)
☐ Gastrointestinal (Crohn's, colitis, ulcer, digestive)
☐ Genitourinary (kidney, STD)
☐ Integumentary (eczema, rosacea, psoriasis)
☐ Lymphatic / Hematologic (anemia, bleeding,leukemia)
☐ Musculoskelatal (fibromyalgia, ankylosing spondylitis)
☐ Neurological (MS, epilepsey)
☐ Psychiatric (depression, panic disorder)
☐ Respiratory (asthma, bronchitis, emphysema, etc.)
☐ None

DAILY VISION CONCERNS, HOBBIES, SPORTS or SPECIAL INTERESTS (check those that apply)

Have you noticed glare:

On gray hazy days..... Y / N
Sunny days..... Y / N
With computer use..... Y / N

Do you wear sunglasses..... Y / N

Have you had Aniti Reflective coating in the past or the present?..... Y / N

☐ Baseball ☐ Golf ☐ Sewing
☐ Basketball ☐ HomeWorkshop ☐ Soccer
☐ Boating ☐ NeedleWork ☐ Tennis
☐ Computers/Gaming ☐ Reading ☐ Other _____

PAYMENT POLICY:

Payment is required at the time of service. Most Insurance companies pay only a portion of your total charges. If you have questions about your coverage, please contact your insurance representative. All insurance referrals need to be given to us **BEFORE** services. We can not guarantee the accuracy of benefit information given to us by insurance companies!

I understand that there may be tests or services that my insurance company will not pay for.
I agree to pay any additional charges not covered by my insurance company for these tests or services.

Please understand that the financial responsibility is yours, not your insurance company's.

How will you settle your account today? ☐ Cash ☐ Check ☐ Credit Card

Patient / Guardian Signature _____

(Your signature constitutes " Signature on File " for insurance purposes)

I consent to the release of verbal information regarding my diagnosis/ test results / treatment plans to my:

☐ *Spouse* _____ ☐ *Children* _____ ☐ *Family Member* _____

Thank you for choosing our office for your eye care needs!

Doctors' Review:

Patient Reviewed and Updated Information - All changes were initialed and dated:

_____ _____ _____ _____ _____ _____

(Doctor Initials/Date)