

PATIENT INFORMATION

Name _____
Patient's Last Name First Name MI

Prefer to be called _____ Marital Status M/S/W/D Sex M / F

Home Address _____

City _____ State _____ Zip _____

Home Phone _____ Office Phone _____

Date of Birth _____ Age _____ Cell Phone: _____

Employer _____ City _____

Occupation _____ Date of Last Eye Exam _____

Family Doctor _____ Date of Last Medical Exam _____

Insurance that would pay for eyecare, if any _____

If married, give name of spouse _____

If under 18, please give parents name _____

Emergency Contact _____ Phone _____

Name of other family members who are patients at this office: _____

Who may we thank for referring you? _____

Reason for visit or any problems you are having with your vision, glasses or contacts: _____

ALL PROFESSIONAL SERVICES ARE PAYABLE AT THE TIME OF VISIT.
 How will you be paying? Cash Check VISA/MasterCard Insurance
Glasses and contact lenses require 50% deposit when ordering.

Signature of Patient or responsible person: _____ Date _____

INSURANCE INFORMATION Same as patient

Vision Insurance	Policy Holder	Policy ID#	Last 4 Digits of SS#	Insured's Date of Birth
Primary Insurance	Policy Holder	Policy ID#	Employer	Insured's Date of Birth
Secondary Insurance	Policy Holder	Policy ID#	Employer	Insured's Date of Birth

INSURANCE PATIENTS PLEASE SIGN BELOW

PATIENTS OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below

SIGNED _____ DATE _____

SIGNED _____ DATE _____

INSURANCE COPAYMENTS AND OVERAGES MUST BE PAID IN FULL BEFORE GLASSES OR CONTACT LENSES ARE ORDERED.

Patient History Form

Today's Date _____

Patient Name _____ Patient Date of Birth _____

Medical History

Are you allergic to any medications? No Yes (describe) _____

Please list any current medications (with dosage) you are taking (including over-the-counter eye drops, vitamins or supplements, aspirin and oral contraceptives).

List any major injuries, surgeries and/or hospitalizations you have had and date(s). _____

Are you pregnant or nursing? Yes No

Have you had any of the following:

- Crossed eyes Lazy eye Drooping eyelid Eye infection
 Eye injury Eye surgery Glaucoma Cataracts Macular degeneration

Do you or have you ever experienced any problems in the following areas?

System	No	Yes	Endocrine	No	Yes	Gastrointestinal	No	Yes
Fever/Weight loss/Gain	N	Y	Non-insulin Dependent Diabetes	N	Y	Crohn's	N	Y
			Insulin Dependent Diabetes	N	Y	Colitis	N	Y
			Thyroid Dysfunction	N	Y	Ulcer	N	Y
			Hormonal Dysfunction	N	Y	Digestive	N	Y
Integumentary								
Eczema	N	Y						
Psoriasis	N	Y						
Cancer	N	Y						
Neurological								
Headaches	N	Y						
Migraines	N	Y						
Seizures	N	Y						
Multiple Sclerosis	N	Y						
Cancer	N	Y						
Ear/Nose/Throat								
Allergies/Hay Fever	N	Y						
Sinus Congestion	N	Y						
Chronic Cough	N	Y						
Dry Throat/Mouth	N	Y						
			Respiratory			Genitourinary		
			Asthma	N	Y	Genitals/Kidney/Bladder	N	Y
			Chronic Bronchitis	N	Y			
			Emphysema	N	Y	Allergy/Immunological		
			Cancer	N	Y	Drug Allergy	N	Y
						Environmental Allergy	N	Y
			Vascular/Cardiovascular			Rheumatoid Arthritis	N	Y
			High Blood Pressure	N	Y	Lupus	N	Y
			High Cholesterol	N	Y			
			Stroke	N	Y	Psychiatric		
			Heart Disease	N	Y	Depression	N	Y
						Panic Disorder	N	Y
			Lymphatic/Hematological			Schizophrenia	N	Y
			Bleeding Problems	N	Y			

Your Eye Symptoms - Do you (patient) experience any of the following?

Blurred Vision	N	Y	Flashing Lights	N	Y	Seeing Rings Around Lights	N	Y
Distorted Vision	N	Y	Painful Eyes	N	Y	Color vision Difficulties	N	Y
Double Vision	N	Y	Gritty/Sandy Eyes	N	Y	Depth Perception Problem	N	Y
Red Eyes	N	Y	Aching Eyes	N	Y	Losing Place While Reading	N	Y
Watery Eyes	N	Y	Drawing/Pulling	N	Y	Night Vision Problems	N	Y
Itchy Eyes	N	Y	Dizziness	N	Y	Extreme Light Sensitivity	N	Y
Burning Eyes	N	Y	Excessive Squinting	N	Y	Discharge From Eyes	N	Y
Dry Eyes	N	Y	Other _____			Floating Spots	N	Y

Family History - Has anyone in the patient's family (blood relative) had any of the following?

Cataracts	N	Y	Glaucoma	N	Y	Heart Disease	N	Y
Cornea Disease	N	Y	Lazy Eye	N	Y	Diabetes	N	Y
Crossed Eyes	N	Y	Macular Degeneration	N	Y	High Blood Pressure	N	Y
Retina Disease	N	Y	Cancer	N	Y	Other _____		

Social History - This information is kept strictly confidential. However, you may discuss this portion directly with your doctor if you prefer.

Yes, I would prefer to discuss my Social History Information directly with the doctor.

Occupation: _____

Do you drive? No Yes If yes, do you have visual difficulty while driving? _____

If yes, please describe: _____

Do you use tobacco? No Yes If yes, type/amount/how long? _____

Do you drink alcohol? No Yes If yes, type/amount/how long? _____

Hobbies/Recreation/Sport - Please mark the boxes that apply to you

- Boating/fishing Gardening Photography Sewing Card playing Golf Racquetball/handball Flying Swimming/Scuba Crafts Hunting Skiing Music

Do you wear: Glasses Contact Lenses

Type of contact lenses: Rigid Soft Extended Wear Other Are they comfortable? No Yes

How often do you replace your contact lenses? Daily 1-2 weeks Monthly Quarterly Yearly Other _____

What brand of contact lenses do you wear? _____

Please provide any additional information you would like to add?

The information provided is true and complete to the best of my knowledge.

Patient Signature (or Guardian if patient is a minor)	Date
Name of person Completing Form (if not patient)	Relationship to Patient