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 _____

MEDICAL INSURANCE INFORMATION Insurance Company _____

Insured's Name _____ Phone Number _____

Insured's Address _____
Street City State Zip Code

Date of Birth _____

Insured's Employer _____

SECONDARY MEDICAL INSURANCE INFORMATION Insurance Company _____

Insured's Name _____ Phone Number _____

Insured's Address _____
Street City State Zip Code

Date of Birth _____

Insured's Employer _____

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.

SIGNED _____ DATE _____

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 _____

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 Constitutional	No	Yes
Fever/Weight loss/Gain	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

Endocrine	No	Yes
Non-insulin Dependent Diabetes	N	Y
Insulin Dependent Diabetes	N	Y
Thyroid Dysfunction	N	Y
Hormonal Dysfunction	N	Y
Respiratory		
Asthma	N	Y
Chronic Bronchitis	N	Y
Emphysema	N	Y
Cancer	N	Y
Vascular/Cardiovascular		
High Blood Pressure	N	Y
High Cholesterol	N	Y
Stroke	N	Y
Heart Disease	N	Y
Lymphatic/Hematological		
Bleeding Problems	N	Y

Gastrointestinal	No	Yes
Crohn's	N	Y
Colitis	N	Y
Ulcer	N	Y
Digestive	N	Y
Genitourinary		
Genitals/Kidney/Bladder	N	Y
Allergy/Immunological		
Drug Allergy	N	Y
Environmental Allergy	N	Y
Rheumatoid Arthritis	N	Y
Lupus	N	Y
Psychiatric		
Depression	N	Y
Panic Disorder	N	Y
Schizophrenia	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? N Y If yes, do you have visual difficulty while driving?_____

If yes, please describe: _____

Do you use tobacco? N Y If yes, type/amount/how long?_____

Do you drink alcohol? N Y 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 your 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