Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your vision health.

PATIENT INFORMATION

Sex ☐ M ☐ F

Last Name_______________________ First Name_______________________ Middle Initial______
Adddress_______________________City_______________________State_______Zip__________
Home Phone_______________________ Business Phone_______________________ Cell Phone______________
Birthdate_______________________ Age__________ Soc. Sec. #_______________________
Marital Status________ Occupation/Grade_______________________Employer/School_______________________
Email address_______________________ Emergency Contact_______________________ Emergency Phone______________
Whom may we thank for referring you to our office? ☐ Family ☐ Friend ☐ Newspaper ☐ Phonebook ☐ Location ☐ Sign ☐ Other

Guardian or Spouse Information

Spouse

Last Name_______________________ First Name_______________________ Middle Initial______
Address_______________________ City_______________________ State________ Zip__________
Spouse's Date of Birth_______________________ Spouse's Occupation_______________________
Spouse's Phone_______________________ Business Phone_______________________ Cell Phone_______________________
Guardian_______________________ Person Responsible for Account_______________________

PRIMARY INSURANCE

Name of insured_______________________ Relationship to patient__________________
Birthdate_______________________ Soc. Sec. # _______________________
Name of employer _______________________Date Employed_______________________
Address of employer_______________________ City_______________________ State_____________ Zip_________
Insurance Company_______________________ Policy/Contract ID #_______________________ Group#_______

ADDITIONAL INSURANCE

Is Patient covered under additional insurance? Yes ☐ No ☐ If Yes Please List:
Name of insured_______________________ Relationship to patient__________________
Birthdate_______________________ Soc. Sec. # _______________________
Name of employer _______________________Date employed_______________________
Address of employer_______________________ City_______________________ State_____________ Zip_________
Insurance Company_______________________ Policy/Contract ID #_______________________ Group#_______

STATEMENT OF FINANCIAL POLICY

As a service to you this office offers several means of payment for the services and materials. It is customary to pay the professional fees for the examination and office visits the same day the services are rendered. When glasses or contacts lenses are ordered, we ask that a 50% deposit be made at the time the materials are ordered with the balance due upon delivery. To ensure that we understand how you want your account handled, please read this statement carefully; check the payment plan which you prefer and sign in the space indicated. If you have questions please feel free to ask before you make your choice.

☐ Check ☐ Cash ☐ MC/Visa/Discover ☐ Medicare ☐ Medicaid ☐ Blue Cross ☐ VSP/VCP ☐ Other______________

Any deductibles or co-payments must be paid at the time of visit. If insurance company is not listed above please list in the "other blank" or check with our receptionist to see if it is a plan we accept.

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered, and I understand that providing incorrect information can be dangerous to my health. I authorize the eye doctor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my dependents during the period of such eye care to third party payers and /or health practitioners. I authorize and request my insurance company to pay directly to eye doctor or ophthalmic group insurance benefits authorize payable to me. I agree to be responsible for payment of all services rendered on my behalf or my dependents. There will be a $30 service charge on all returned checks. If my account becomes delinquent, I agree to pay all collection fees.

_______________________________________ _______________________________________
Signature of Patient, Parent, Guardian Date

PATIENT HISTORY

Please list the reason for your visit with us today____

Primary Care Physician and Clinic Name/Telephone#____

Address of Primary Care Physician ______________________ City __________ State ______Zip______________

Date of your last medical exam__________________________

List Medications you are presently taking:

_________________________________ For_________________________________

_________________________________ For_________________________________

_________________________________ For_________________________________

_________________________________ For_________________________________

_________________________________ For_________________________________

List any medications that you are allergic to: ____

Current Eye drops: ____

PERSONAL HEALTH HISTORY

Check ✔ any of the following problems which you have or have had in the past:

- ☐ Anxiety or Depression
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Cough up Blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Head Injury
- ☐ Heart Murmur
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV/AIDS
- ☐ Hospitalization in past 5 years
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of feet or ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease

Have you ever had any serious illnesses or operations? ☐ Yes ☐ No If yes please explain: ______________________________

(Women) Are you Pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control? ☐ Yes ☐ No

PERSONAL EYE HISTORY

Check ✔ any of the following problems which you have or have had in the past:

- ☐ Amblyopia (lazy eye)
- ☐ Blindness
- ☐ Blurred Vision Distance
- ☐ Blurred Vision Near
- ☐ Cataracts
- ☐ Color Blindness
- ☐ Crossed Eyes
- ☐ Drooping Eyelid
- ☐ Eye disease or infection
- ☐ Eye injury
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Retinal Detachment
- ☐ Strabismus (Crossed Eyes)
- ☐ Surgery for your Eyes: explain__________

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FAMILY HISTORY

Please note any family history (parents, grandparents, sibling, children; living or deceased) for the following conditions:

Disease/Conditions	Relationship to You
Arthritis	____________________
Blindness	____________________
Cataracts	____________________
Cancer	____________________
Crossed Eyes	____________________
Color Blindness	____________________
Diabetes	____________________
Glaucoma	____________________

Disease/Conditions	Relationship to You
Heart Disease	____________________
High Blood Pressure	____________________
Kidney Disease	____________________
Lupus	____________________
Macular Degeneration	____________________
Retinal Detachment	____________________
Thyroid Disease	____________________
Other	____________________

VISION HISTORY

Date of Last Eye Examination________________________________ Name of Previous Eye Doctor_______________________________
Location of previous eye doctor____

Do you currently wear glasses? ☐Yes ☐No and if so what were the glasses for? ☐Full time ☐Reading ☐Distance only ☐Near only ☐ Computer

Does bright sunlight bother your eyes? ☐Yes ☐No

Do you use a computer? ☐Yes ☐No

List your Hobbies: ____

What hobbies or sports do you participate in that you have difficulty with your vision? ____

Do you have prescription sunglasses? ☐Yes ☐No

Do you experience glare problems? ☐Yes ☐No

SPECIAL EYEWEAR NEEDS

☐Computer ☐Occupational ☐Safety Glasses ☐Sports/Hobbies

CONTACT LENS HISTORY

Have you ever worn contacts before? ☐Yes ☐No

And if so what do you currently wear? Brand_______________ Prescription: Right_____________________
Left__________________

How many hours/day? ________ How many days/weeks? ________ (information is on boxes)

What solutions do you use? ____________________________

And if not are you interested in wearing contacts? ☐Yes ☐No

Are you satisfied with current contact lens? ☐Yes ☐No

SOCIAL HISTORY

Do you use nutritional supplements (vitamins etc.)? ☐Yes ☐No

Do you engage in regular exercise? ☐Yes ☐No

Do you drink alcohol? ☐No ☐Occasional

Do you smoke? ☐Yes ☐No if yes, how much/often: ☐1/2 pkg day ☐1 pkg day ☐1+pkg day

Method of tobacco used? ☐Smoking ☐Chewing

Do you use illegal drugs? ☐Yes ☐No