



Welcome Back to Our Office

(Please Print)
Today's Date:
Name:
Street:
City:
State: Zip:
Home Phone:
Work Phone:
Employer (or School):
Occupation (or Grade):
Social Security Number:
Spouse (or Parent's Name):
Date of Birth: Age: Sex: Male Female
Email Address:
What is the purpose of this visit?
Any problems with your present contact lenses or glasses?

INSURANCE INFORMATION

Vision Insurance:
Subscriber Name:
Subscriber SSN:
Subscriber Birth Date:

Primary Medical Insurance

Subscriber Name:
Subscriber SSN:
Subscriber Birth Date:
Do you participate in a flex spending account?
Cash Check Credit Card

Family Medical/Eye History (check all that apply):

Is there a family history of any of the following?
Blindness Relationship
Cataracts Relationship
Comeal Transplant Relationship
Lazy Eye Relationship
Glaucoma Relationship
Retinal Problems Relationship
Macular Degeneration Relationship
Diabetes Relationship
Heart Disease Relationship

Please be aware that most eye health plans do not cover contact lens services and these will be billed separately. Please be aware that your vision insurance is a contract between you and your insurance company and not us. We will help you fill out insurance forms and submit them for you. However, if your insurance company has not paid us in 90 days, we will put the balance on your credit card.

The information in this confidential case history form is critical to the evaluation of your vision and health.

PATIENT MEDICAL HISTORY

Name of Family Physician:
Town:
Date of Last Physical Check-up:

CURRENT MEDICATIONS (Rx or Over the Counter)

(List name of medications including eye drops, vitamins, & birth control pills)
Allergies to Medications:
Do you smoke?
Do you drink?
Do you use illegal drugs?

What kind?
How many per week?
Have you ever been diagnosed or treated for the following?
Allergies Diabetes Thyroid Asthma Heart Disease Other
Arthritis High Blood Pressure Cancer Kidney
Cholesterol Nerves

PATIENT EYE HISTORY

Date of Last Eye Exam:
By Whom?

Do you currently wear contact lenses?
What kind?
Solutions used?

Would you prefer clear contact lenses or colored contact lenses to change the color of your eyes?
Have you ever tried contact lenses?

Do you... (Check box if your answer is yes)

Work at a computer?
Think you might benefit from thinner, lighter lenses?
Have interest in a "Test Drive" of the latest contact lens designs?
Spend time outdoors?
Have prescription sunglasses?
Prefer not to wear your glasses at times?
Want information on Laser Vision Correction surgery?
Have interest in a non-surgical approach to vision correction?
Have more than 1 pair of prescription glasses?
Have children?
Have family members in need of eyecare?
If you wear bifocals, do the lines or head tilting bother you?
If you wear contact lenses, are you satisfied with the vision and comfort?

Have you ever been diagnosed or treated for the following?

Cataracts Iritis/Uveitis
Corneal Abrasion Lazy Eye
Eye Infection Macular Degeneration
Eye Injury Retinal Detachment
Glaucoma Other Eye Disorders

Do you experience or have you ever experienced?

Blurry Vision Flash of Light Sunlight Sensitivity
Burning Floaters/Spots Crossed Eye/Eye Turn
Tearing Grittiness Trouble Seeing at Night
Headaches Itchiness Uncomfortable Glasses
Double Vision Occasional Dryness