



Welcome to Our Office

(Please Print)

Today's Date: _____

Name: _____

Street: _____

City: _____

State: _____ Zip: _____

Home Phone: _____

Work Phone: _____

Emergency Contact: _____

Emergency Contact 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? _____

VERY IMPORTANT! NEW PATIENTS ONLY:

Who may we thank for referring you to our office? _____

Name of friend or relative: _____

If not referred, how did you choose our office for your needs?

Another Doctor Insurance List

Saw Sign/Building Newspaper/Radio/TV

Yellow Pages: Which directory? _____

Web Page: Which Web Site? _____

Other: _____

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? Yes No

Cash Check Credit Card

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

Is there a family history of any of the following?

Table with 4 columns: Condition, Relationship, Condition, Relationship. Rows include Blindness, Corneal Transplant, Glaucoma, Macular Degeneration, Heart Disease, Cataracts, Lazy Eye, Retinal Problems, Diabetes.

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: Yes No

Do you smoke? Yes No

Do you drink? Yes No

Do you use illegal drugs? Yes No

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? Yes No

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? Yes No

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

Work at a computer? If so, how many hours a day? _____

Think you might benefit from thinner, lighter lenses?

Have interest in a "Test Drive" of the latest contact lens designs?

Spend time outdoors? (How much? _____ hrs/week) _____

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?

Yes No

If you wear contact lenses, are you satisfied with the vision and comfort? Yes No

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