

WELCOME TO OUR OFFICE

Today's Date _____



Patient Information

Last _____
First _____ MI _____
Street _____
City _____ State _____
Zip Code _____
Home Phone _____
Work Phone _____
Employer (or School) _____
Occupation (or Grade) _____
Spouse (or Parent's Name) _____
Date of Birth _____ Age _____
Sex M F
Email Address _____

VERY IMPORTANT! NEW PATIENTS ONLY:

Who may we thank for referring you to our office?

If not referred, how did you choose our office?

- Another Dr.
- Insurance List
- Saw Sign/Building
- Newspaper/Radio/TV
- Yellow Pages: Which directory? _____
- Web Page: Which Web Site? _____
- Other _____

Insurance Information

Please note that the patient is responsible for all fees not covered by their insurance/vision plan. Payment is expected at the time of service.

Routine Vision Insurance _____
Subscriber Name _____
Subscriber id # _____
SS# _____
Subscriber Birth Date _____

Medical Insurance _____
Subscriber Name _____
Subscriber id # _____
SS# _____
Subscriber Birth Date _____

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits wither to myself or to the party who accepts assignment.

X _____

Lifestyle Questions

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

- ..work at a computer?
- ..think you might benefit from thinner, lighter lenses?
- ..currently wear or are you interested in contact lenses?
- ..spend a lot of time outdoors?
- ..have prescription sunwear?
- ..prefer not to wear your glasses at times?
- ..want information on Laser Vision Correction surgery?
- ..have more than 1 pair of current Rx eyewear?
- ..have family members in need of eyecare?

Patient Eye History

Have you ever experienced, been diagnosed or treated for any of the following?

- | | |
|--|--|
| <input type="checkbox"/> Blurry Vision | <input type="checkbox"/> Cataracts |
| <input type="checkbox"/> Double Vision | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Crossed /Lazy Eye | <input type="checkbox"/> Macular Degeneration |
| <input type="checkbox"/> Floaters | <input type="checkbox"/> Retinal Detachment |
| <input type="checkbox"/> Flashes of light | <input type="checkbox"/> Corneal Abrasion |
| <input type="checkbox"/> Dry Eyes | <input type="checkbox"/> Sunlight Sensitivity |
| <input type="checkbox"/> Burning Eyes | <input type="checkbox"/> Trouble seeing at night |
| <input type="checkbox"/> Itchy Eyes | <input type="checkbox"/> Eye Surgery |
| <input type="checkbox"/> Tearing | <input type="checkbox"/> Eye Injiry |

Family Eye History (Check all that apply)

Is there a family medical history of any of the following:

- Blindness
- Cataracts
- Corneal Problems
- Diabetic Eye Disease
- Glaucoma
- Lazy Eye
- Macular Degeneration
- Retinal Problems

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 _____

How long has it been since your last physical?

Please list all medications you are currently taking including eye drops, vitamins, birth control, and over the counter. _____

Please list any allergies to medications. None known

How long has it been since your last eye exam?

Please list any previous eye injuries or surgeries.

Have you ever been diagnosed or treated for the following health problems? Yes No

- | | | |
|-----------------------------|--------------------------|--------------------------|
| Allergies | <input type="checkbox"/> | <input type="checkbox"/> |
| Arthritis | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood/Lymph | <input type="checkbox"/> | <input type="checkbox"/> |
| Bronchitis | <input type="checkbox"/> | <input type="checkbox"/> |
| Cancer | <input type="checkbox"/> | <input type="checkbox"/> |
| Cholesterol | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> |
| Digestive | <input type="checkbox"/> | <input type="checkbox"/> |
| Ears/Nose/Throat | <input type="checkbox"/> | <input type="checkbox"/> |
| Endocrine | <input type="checkbox"/> | <input type="checkbox"/> |
| Eczema/Rashes | <input type="checkbox"/> | <input type="checkbox"/> |
| Fatigue | <input type="checkbox"/> | <input type="checkbox"/> |
| Fevers | <input type="checkbox"/> | <input type="checkbox"/> |
| Genitourinary | <input type="checkbox"/> | <input type="checkbox"/> |
| High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> |
| Integumentary (Skin) | <input type="checkbox"/> | <input type="checkbox"/> |
| Kidney | <input type="checkbox"/> | <input type="checkbox"/> |
| Muscle/Bone | <input type="checkbox"/> | <input type="checkbox"/> |
| Neurological | <input type="checkbox"/> | <input type="checkbox"/> |
| Psychological | <input type="checkbox"/> | <input type="checkbox"/> |
| Respiratory | <input type="checkbox"/> | <input type="checkbox"/> |
| Sinus | <input type="checkbox"/> | <input type="checkbox"/> |
| Throat Infections | <input type="checkbox"/> | <input type="checkbox"/> |
| Thyroid | <input type="checkbox"/> | <input type="checkbox"/> |
| Unusual weight losses/gains | <input type="checkbox"/> | <input type="checkbox"/> |