Please have all paperwork completely filled out and back to our office before your appointment date. You can mail it to us or drop it off. Please allow at least 3 days before your appointment for mailing. We must have this paperwork completed in order to file your insurance. Thank you for your cooperation and we look forward to seeing you soon.

Welcome to . Thank you for choosing us for your eyecare needs. We are delighted to have you as a patient and appreciate the confidence you placed in us. Please take a moment to review/complete the following information.

☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms. ☐ Male ☐ Female

First Name | MI | Last Name | Preferred Name

Street Address | City | State | Zip

Social Security Number | Date of Birth | Home Phone - Include Area Code | Work Phone

Email Address | Spouse or Parent(s) Name | Person Responsible for Account

Emergency Contact | Emergency Phone

How were you referred to our office?

☐ Phone Book ☐ School ☐ Advertisement ☐ Patient (Please Name) _____

☐ Insurance Listing ☐ Drive by ☐ Other _____ ☐ Doctor (Please Name) _____

P

Name and Address of Primary Insurance Company | City | State | Zip

M ☐ F ☐ Insured's First Name | MI | Insured's Last Name

Insured's Identification Number | Group Number | Insured's Date of Birth

Patient Relationship to Insured

☐ Self ☐ Spouse ☐ Child ☐ Other

Patient Status

☐ Single ☐ Married ☐ Other

☐ Full Time Student ☐ Part Time Student ☐ Employed

SECONDARY INSURANCE INFORMATION

Name and Address of Secondary Insurance Company | City | State | Zip

M ☐ F ☐ Insured's First Name | MI | Insured's Last Name

Patient Relationship to Insured

Insured's Identification Number | Group Number | Insured's Date of Birth

☐ Self ☐ Spouse ☐ Child ☐ Other

Please Read and Sign:

The patient's portion is due at the time services are rendered unless other arrangements are made in advance. All professional services and materials are charged to the patient. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Accounts 90 days old are subject to collection fees. There will be a service charge on all returned checks.

Payment from my insurance is to be paid directly to . I understand that the above primary insurance will be billed on my behalf. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed.

My signature below includes achknoledgement of the **Notice of Privacy Practices** of .

Signature | Date

Name

PATIENT HISTORY AND INFORMATION

PRIMARY CARE PHYSICIAN

Primary Care Physician and Clinic Name

Address of Primary Care Physician City State Zip Phone

REFERRING PHYSICIAN

Referring Physician and Clinic Name

Address of Referring Physician City State Zip Phone

HEALTH HISTORY

What is the main reason for today's exam ? When was your last exam ?

When was your last health exam ?

Past Illnesses or Injuries:

Past Surgeries:

Current Medications:

Current Eye Drops:

Medicines that cause reactions or sensitivities:

Specific Allergies:

EYE HISTORY

Glaucoma	O Yes O No	Dryness	O Yes O No	Strabismus (Crossed Eyes)	O Yes O No
Cataract	O Yes O No	Excess Tearing/Watering	O Yes O No	Blurred Vision Distance	O Yes O No
Macular Degeneration	O Yes O No	Eye Pain or Soreness	O Yes O No	Blurred Vision Near	O Yes O No
Retinal Detachment	O Yes O No	Foreign Body Sensation	O Yes O No	Distorted Vision (halos)	O Yes O No
Color Blindness	O Yes O No	Infection of Eye or Lid	O Yes O No	Double Vision	O Yes O No
Headaches	O Yes O No	Itching	O Yes O No	Floaters or Spots	O Yes O No
Glare/Light Sensitivity	O Yes O No	Mucous Discharge	O Yes O No	Fluctuating Vision	O Yes O No
Tired Eyes	O Yes O No	Drooping Eyelid	O Yes O No	Loss of Vision	O Yes O No
Amblyopia (Lazy Eye)	O Yes O No	Redness	O Yes O No	Loss of Side Vision	O Yes O No
Burning	O Yes O No	Sandy or Gritty Feeling	O Yes O No		

GENERAL HEALTH CONDITION

Fever	O Yes O No	Respiratory (Asthma)	O Yes O No	Anxiety or Depression	O Yes O No
Weight Loss	O Yes O No	Gastrointestinal	O Yes O No	Endocrine (Thyroid, Diabetes)	O Yes O No
Other Symptoms	O Yes O No	Kidney	O Yes O No	Blood/Lymph	O Yes O No
Ears,Nose,Throat	O Yes O No	Muscles,Bones,Joints	O Yes O No	Allergic	O Yes O No
Cardiovascular (high blood pressure etc.)	O Yes O No	Skin	O Yes O No	Are you?	☐ Pregnant ☐ Nursing
		Neurological (Multiple Sclerosis)	O Yes O No		

FAMILY HISTORY

Amblyopia (Lazy Eye)	O Yes O No	Retinal Detachment	O Yes O No	High Blood Pressure	O Yes O No
Blindness	O Yes O No	Strabismus (Eye Turn)	O Yes O No	Kidney Disease	O Yes O No
Cataract(s)	O Yes O No	Arthritis	O Yes O No	Lupus	O Yes O No
Color Blindness	O Yes O No	Cancer	O Yes O No	Stroke	O Yes O No
Glaucoma	O Yes O No	Diabetes	O Yes O No	Thyroid Disease	O Yes O No
Macular Degeneration	O Yes O No	Heart Disease	O Yes O No	Others	O Yes O No

Name

MEDICAL HISTORY QUESTIONAIRE

SOCIAL HISTORY

Current Occupation : _____ Years _____ Employer _____

SPECTACLE LENS HISTORY

Do you use a computer? O Yes O No How many hours/day? _____ Distance from Computer? _____

Do you drive? O Yes O No Mileage to work each way? _____ Do you have glare problems? O Yes O No

Do you have visual difficulty when driving? O Yes O No

Do you have problems with night vision? O Yes O No

Do you currently wear glasses ? O Yes O No Since _____

Type of glasses ☐ FullTime ☐ PartTime ☐ Distance ☐ Close

Glasses Owned

☐ SingleVision ☐ Bifocals ☐ Trifocals ☐ Backup ☐ Safety ☐ Sports ☐ Progressive

Have you had trouble in the past with glasses? O Yes O No _____

Do you wear sunglasses? O Yes O No Are your sun glasses your current prescription ? O Yes O No

SPECIAL EYEWEAR NEEDS

☐ Computer (special prescriptions, special anti-glare tints or coatings) ☐ Safety Glasses (gardening, woodworking, welding)
☐ Occupational (mechanics, plumbers, pilots) ☐ Sports/Hobbies (racquet sports, motorcycle)

CONTACT LENS HISTORY

Have you ever tried to wear contact lenses? O Yes O No Reason for stopping? _____

Do you currently wear contact lenses? O Yes O No Since _____

If not a contact lens wearer, are you interested in trying contact lenses at this time ? O Yes O No

Type and brand of contact lenses _____ Today's wearing time ? _____

How many hours/day ? _____ How many days/week ? _____

Please rate the following on a scale of 1-10, with 1 being POOR to 10 being EXCELLENT

	Right	Left		Right	Left		Right	Left
Lens Comfort	_____	_____	Distance Vision	_____	_____	Near Vision	_____	_____

What Solutions do you use? Cleaner _____ Disinfectant _____ Enzyme _____

SOCIAL HISTORY

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

Do you engage in regular exercise? O Yes O No

Do you drink alcohol ? If yes, how much/often : O No O Occasional O 1 per day O 2-3/day O 4+/day

Do you smoke ? If yes, how much/often : O No O Occasional O 1/2 pack/day O 1 pack/day O 1+ pack

Method of Tobacco Intake : O Smoking O Chewing

Do you use Illegal Drugs : O Yes O No

Hobbies/ Interests : _____

Last Health Exam _____