Patient Information

ID Card Photo- copy

Date:___/___/___

_____
First M Last

_____
Address

_____
City State Zip

_____ _____
Date of Birth Age Social Security

_____ _____
Home Phone Work / Cell Phone

_____ _____
Occupation Email Address

Additional Information:
Policy Holder's Employer:
Marital Status:

Medical Information

1. Who is your Primary Care Physician?_____
   Address: _____
   _____
   Phone: _____

2. How did you hear of us? _____
   _____

3. Date of last eye examination: _____

4. What is the primary reason for your visit today?
   _____
   _____
   _____

5. Do you wear glasses? ❑ Yes ❑ No
   How old are they?_____

6. Do you wear contact lenses? ❑ Yes ❑ No
   If not, are you interested in wearing them? ❑ Yes ❑ No
   Soft / RGP / Hard (please circle one)
   If disposable, replacement schedule _____
   How many hours/day do you wear them? _____
   Do you sleep in them? ❑ Yes ❑ No
   What solutions do you use to care for them? _____

7. Hours/day of computer use _____
   Frequent eyestrain from computer use? ❑ Yes ❑ No
   Frequent headaches from computer use? ❑ Yes ❑ No

8. Please list **ALL** medications that you are currently taking (including aspirin and aspirin like products, hormones, birth control pills, over the counter medications, and vitamins):
   _____
   _____
   _____
   _____

9. EYE HEALTH HISTORY

Blindness	❑ Yes	❑ No
Bloodshot/Red Eyes	❑ Yes	❑ No
Blurred Vision	❑ Yes	❑ No
Burning Eyes	❑ Yes	❑ No
Cataracts	❑ Yes	❑ No
Color Vision Poor	❑ Yes	❑ No
Corneal Disease	❑ Yes	❑ No
Crossed/Turned Eyes	❑ Yes	❑ No
Discharge From Eyes	❑ Yes	❑ No
Dizzy Spells	❑ Yes	❑ No
Droopy Eyelid	❑ Yes	❑ No
Double Vision	❑ Yes	❑ No
Dry Eyes	❑ Yes	❑ No
Eye Infection	❑ Yes	❑ No
Eye Surgery	❑ Yes	❑ No
Eye Injury	❑ Yes	❑ No
Eye Lid Problems	❑ Yes	❑ No
Eye Strain	❑ Yes	❑ No
Fainting Spells/Blackouts	❑ Yes	❑ No
Floaters or Spots	❑ Yes	❑ No
Flashes of Light	❑ Yes	❑ No
Glare with Driving	❑ Yes	❑ No
Glaucoma	❑ Yes	❑ No
Headaches	❑ Yes	❑ No
Itchy Eyes	❑ Yes	❑ No
Laser Treatment	❑ Yes	❑ No
Light Sensitivity	❑ Yes	❑ No
Loss of Vision	❑ Yes	❑ No
Macular Degeneration	❑ Yes	❑ No
Migraine Headaches	❑ Yes	❑ No
Night Vision Poor	❑ Yes	❑ No
Peripheral Vision Poor	❑ Yes	❑ No
Retinal Disease	❑ Yes	❑ No
Seeing Halos	❑ Yes	❑ No
Temporary Vision Loss	❑ Yes	❑ No
Twitching Eyelid	❑ Yes	❑ No
Watering Eyes	❑ Yes	❑ No

10. Please list any medications you are allergic to and the reaction that occurs: _____
_____

11. Please list any other allergies you have: _____
_____

12. If you are being treated for any ongoing medical condition, please describe: _____
_____
_____

13. Are you experiencing (please circle):
Fever Weight Loss Malaise Frequent Urination
Excessive Thirst?

14. Do you smoke? ❑ Yes ❑ No # Packs/day _____
years _____ or Quit date _____

15. Do you drink alcohol? ❑ Yes ❑ No How often? _____

16. Do you live alone? ❑ Yes ❑ No

18. Family Health History

Arthritis	❑ Yes	❑ No	Who? _____
Cancer	❑ Yes	❑ No	Who? _____
Cataracts	❑ Yes	❑ No	Who? _____
Diabetes	❑ Yes	❑ No	Who? _____
Eye Tumors	❑ Yes	❑ No	Who? _____
Glaucoma	❑ Yes	❑ No	Who? _____
Heart Attack/Heart Disease	❑ Yes	❑ No	Who? _____
High Blood Pressure	❑ Yes	❑ No	Who? _____
Macular Degeneration	❑ Yes	❑ No	Who? _____
Retinal Disease	❑ Yes	❑ No	Who? _____
Stroke	❑ Yes	❑ No	Who? _____
Thyroid Disease	❑ Yes	❑ No	Who? _____

19. HEALTH HISTORY

AIDS/HIV	❑ Yes	❑ No
Artificial Joints	❑ Yes	❑ No
Arthritis	❑ Yes	❑ No
Asthma	❑ Yes	❑ No
Autoimmune Disease	❑ Yes	❑ No
Cancer	❑ Yes	❑ No
Chemical Dependency	❑ Yes	❑ No
Drug Sensitivity	❑ Yes	❑ No
Diabetes	❑ Yes	❑ No
Ear, Nose, Throat problem	❑ Yes	❑ No
Emphysema	❑ Yes	❑ No
Epilepsy	❑ Yes	❑ No
Gout	❑ Yes	❑ No
Hayfever	❑ Yes	❑ No
Heart Condition	❑ Yes	❑ No
Hereditary Disease	❑ Yes	❑ No
Hepatitis (Type ____)	❑ Yes	❑ No
Lupus	❑ Yes	❑ No
Kidney/Urinary problems	❑ Yes	❑ No
Migraine Headaches	❑ Yes	❑ No
Multiple Sclerosis	❑ Yes	❑ No
Neurological Disorder	❑ Yes	❑ No
Pacemaker	❑ Yes	❑ No
Psychiatric Condition	❑ Yes	❑ No
Respiratory Disease	❑ Yes	❑ No
Rheumatic Fever	❑ Yes	❑ No
Shingles	❑ Yes	❑ No
Sinus problems	❑ Yes	❑ No
Skin conditions	❑ Yes	❑ No
Stomach/Digestive problems	❑ Yes	❑ No
Stroke	❑ Yes	❑ No
Thyroid Condition	❑ Yes	❑ No
Tuberculosis	❑ Yes	❑ No

Please read and sign.

1. **PAYMENT POLICY:** Full payment is expected at time of service.
2. **INSURANCE POLICY:** 100% of patient balance is required after insurance benefit is applied.
3. **AUTHORIZATION OF PAYMENT AND PATIENT RELEASE I authorize the direct payment of medical/vision benefits to the physician and supplier for services rendered.**

I authorize the release of any medical or other information necessary to process this claim. I accept financial responsibility for any unpaid balance not covered by my vision insurance plan.

I HAVE READ AND UNDERSTAND STATEMENTS 1-3

Patient's Signature:_____ Guardian Signature:_____