WELCOME TO OUR OFFICE

Name: ____ Sex: M / F Birth Date: ____________

Street Address: ____ SS # (Last 4) ________________

City: _______________________________ State: ________ Zip Code: ____________

Phone: Home: (______) ____________ Work: (______) ____________ Cell: (______) ____________

Email: ____ Preferred phone: Home / Work / Cell

Employer: ____ Occupation: ______________________

Vision Benefits Carrier: _________________________ Medical Insurance Carrier: _____________________

We bill participating insurance companies as a courtesy to our patients. Copays and deductibles are due at the time of service. Please ensure that we have updated insurance information, as it will be your responsibility to pay for any services or materials denied by your insurance company. As we frequently bill for vision related as well as medical services for eye care, we will copy and hold your insurance information. Efforts will be made to discuss differences in medical and vision driven eye care with you as appropriate prior to the generation of fees.

Do you currently wear glasses? Y / N ☐ Full Time ☐ Part Time (☐ Distance ☐ Near)

Glasses owned: ☐ Single Vision (Distance / Reading) ☐ Progressives (No-line bifocals) ☐ Bifocals / Trifocals

☐ Computer ☐ Rx Sunglasses ☐ Non-Rx Sunglasses ☐ Sports Glasses for ________ ☐ Rx Safety Glasses

How old is your current pair of "everyday" glasses? ____________

How many hours per day do you use a computer? ________

Do you experience any eye strain or fatigue with ☐ computer use or ☐ reading?

Do you experience any visual difficulty driving during ☐ daytime ☐ nighttime or ☐ rainy/poor weather?

Do you currently wear contact lenses? Y / N Type / Brand of lenses: ____________________

If not wearing now, have you ever tried to wear contact lenses? Y / N Reason for stopping? ________________

I am curious / interested in learning about advances in:

☐ Eyeglasses ☐ Contact Lenses ☐ Laser Vision Correction (LASIK) ☐ Eye Health Condition: ____________

Marital Status: ☐ Married (Spouse's Name:______________) ☐ Single ☐ Divorced / Separated ☐ Widowed

Use of alcohol: ☐ None ☐ Rarely ☐ Moderate If Moderate, please elaborate ________________________

Use of tobacco: ☐ Never ☐ Previously but not in past ________ years ☐ Yes ________ packs / day

How did you first hear about us?

☐ Referral from _________________________ ☐ Internet search / site ___________________________

☐ Insurance list ☐ Driving / walking by office ☐ Other: ________________________________

Eye History: Are you currently taking any prescription or non-prescription drops / medication for your eyes? Y / N

If so, please list: ____

Have you ever had eye surgery? Y / N

☐ Right eye: surgery for: ____________________ Year: __________

☐ Left eye: surgery for: ____________________ Year: __________

Have you or do you now have any of the following conditions?

☐ Glaucoma	☐ Blurred vision	☐ Eye pain	☐ Foreign body sensation
☐ Macular degeneration	☐ Double vision	☐ Redness	☐ Tearing
☐ Cataracts	☐ Flashes of light	☐ Itching	☐ Mucus discharge
☐ Retinal tear / detachment / hole	☐ Floating dark spots	☐ Burning	☐ Crusting
☐ Lazy eye / amblyopia	☐ Light sensitivity	☐ Dryness	☐ Drooping eyelid(s)

General Health History: Have you been treated or monitored for any of the following?

☐ High blood pressure ☐ Diabetes ☐ Heart disease ☐ Cholesterol ☐ Stroke ☐ Cancer ☐ Autoimmune

Primary Care Physician: ____________________________________ Last physical: __________________________

Are you currently experiencing problems with any of the following?	If yes, please explain
☐ Ear / nose / throat (hearing loss, sinus problem, dry mouth, earache, laryngitis)	________________________
☐ Fever / fatigue	________________________
☐ Neurological (numbness, headache, seizures, paralysis)	________________________
☐ Psychiatric (depression, ADD, anxiety, bipolar)	________________________
☐ Heart (chest pain, angina, irregular heart beat)Sudden weight gain or loss	________________________
☐ Respiratory (cough, asthma, shortness of breath, COPD, sleep apnea)	________________________
☐ Gastrointestinal (abdominal pain, heartburn, ulcer, celiac disease)	________________________
☐ Urinary (pain when urinating, blood in urine, prostate hypertrophy, STD)	________________________
☐ Musculoskeletal (joint pain, stiffness or swelling, muscle pain or weakness)	________________________
☐ Skin problems (eczema, roseaca, psoriasis, rash)	________________________
☐ Endocrine (thyroid problems, hormone dysfunction)	________________________
☐ Hematologic / lymphatic (blood disorders, bruising, enlarged glands, anemia)	________________________
☐ Allergic / immunologic (reactions to foods, seasonal)	________________________
☐ Other physical condition	________________________

Family Health: Has anyone in your immediate family been diagnosed with any of the following? If so, which relation?

☐ Blindness	____________________	☐ Retinal tear / detachment	____________________
☐ Cataracts	____________________	☐ Lazy eye (amblyopia)	____________________
☐ Glaucoma	____________________	☐ Diabetes	____________________
☐ Macular degeneration	____________________	☐ Cancer	____________________

Medications: (prescription and over the counter)

____________________ for ____________________ ____________________ for ____________________

____________________ for ____________________ ____________________ for ____________________

____________________ for ____________________ ____________________ for ____________________

____________________ for ____________________ ____________________ for ____________________

Drug Allergies: Y / N
If yes, list the medications

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To the best of my knowledge, the questions on this form have been accurately answered. It is my responsibility to inform the doctor of any changes in my medical status.

____ Date ____________