

Guardian: _____ Date: _____

Name: _____

Address: _____

City, St: _____ Zip: _____

Phone(H): _____ (C): _____

Date of Birth: _____ Sex: _____

Vision or Primary Insurance

Ins.: _____ #: _____

Insured: _____ DOB: _____

Relationship: _____

Medical or Secondary Insurance

Ins.: _____ #: _____

Insured: _____ DOB: _____

Relationship: _____

E-Mail: _____

Notify me by: Text Phone Email Mail

Medical Doctor(s): _____

Approx. Date of Last Eye Exam: _____

Glasses R- _____
L- _____

Contacts R- _____
L- _____

Allergies

- None
- Penicillin
- Sulfa
- Eye drops
- Other...

Current Medicines

Race _____ Ethnicity _____ Language _____

History or Problems

- | | | |
|---------------------------------------|---|--------------------------------------|
| <input type="checkbox"/> Allergy | <input type="checkbox"/> Ear | <input type="checkbox"/> Melanoma |
| <input type="checkbox"/> Amblyopia | <input type="checkbox"/> Eye Infection | <input type="checkbox"/> Migraine |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Eye Injury | <input type="checkbox"/> MS |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Respiratory |
| <input type="checkbox"/> Cataract | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Crossed Eyes | <input type="checkbox"/> High B.P. | <input type="checkbox"/> Stye |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Keratoconus | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Diabetes 1 | <input type="checkbox"/> Kidney | <input type="checkbox"/> Other... |
| <input type="checkbox"/> Diabetes 2 | <input type="checkbox"/> Lasik | |
| <input type="checkbox"/> Droopy Lid | <input type="checkbox"/> Macular Degen. | |

Eye wear History (have you ever worn...)

- | | | | |
|------------------------------------|--|-------------------------------------|---|
| <input type="checkbox"/> Glasses | <input type="checkbox"/> No-line | <input type="checkbox"/> Gas Perm. | <input type="checkbox"/> Disposable |
| <input type="checkbox"/> Bifocals | <input type="checkbox"/> Soft Contacts | <input type="checkbox"/> Hard | <input type="checkbox"/> Overnight wear |
| <input type="checkbox"/> Trifocals | <input type="checkbox"/> Toric Soft | <input type="checkbox"/> Monovision | <input type="checkbox"/> Other... |

Family History (parents, grandparents, siblings)

- | | | |
|---------------------------------------|---|------------------------------------|
| <input type="checkbox"/> Blindness | <input type="checkbox"/> Diabetes II | <input type="checkbox"/> High B.P. |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Crossed Eyes | <input type="checkbox"/> Macular Degen. | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Color Blind | <input type="checkbox"/> Retina Detach | <input type="checkbox"/> None |
| <input type="checkbox"/> Diabetes 1 | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Other... |

Social History

- | | | |
|-----------------------------------|----------------------------------|--|
| <input type="checkbox"/> Computer | <input type="checkbox"/> Skiing | <input type="checkbox"/> Swim |
| <input type="checkbox"/> Reading | <input type="checkbox"/> Golf | <input type="checkbox"/> Bike |
| <input type="checkbox"/> Student | <input type="checkbox"/> Fishing | <input type="checkbox"/> Drug Abuse |
| <input type="checkbox"/> Music | <input type="checkbox"/> Tennis | <input type="checkbox"/> Alcohol Abuse |

Occupation

- Ex-smoker Never smoked tobacco
- Heavy tobacco smoker
- Light tobacco smoker

Current eye problem(s) (please circle the "main" problem)

- | | | |
|---|---|--|
| <input type="checkbox"/> Blur at Far | <input type="checkbox"/> Eye strain | <input type="checkbox"/> Medical eye check |
| <input type="checkbox"/> Blur at Near | <input type="checkbox"/> Flashes/Floaters | <input type="checkbox"/> Other... |
| <input type="checkbox"/> Blur at Far & Near | <input type="checkbox"/> Loss of vision | |
| <input type="checkbox"/> Itching | <input type="checkbox"/> Double vision | |
| <input type="checkbox"/> Burning | <input type="checkbox"/> Sandy/Gritty | |
| <input type="checkbox"/> Redness | <input type="checkbox"/> Spots or shadows | |
| <input type="checkbox"/> Eye pain | <input type="checkbox"/> Diabetes eye check | |

Right eye Left eye Both eyes

Mild Moderate Severe

Started today 3-7 days 2-4 weeks 3-6 months

1-2 days 1-2 weeks 1-3 months Over 6 months

Getting better Getting worse About the same

Are you interested in contact lenses information?

Try Contacts Upgrade Contacts No interest in Contacts

Our office requires payment at the time of service unless we "accept assignment" on your insurance. **You are responsible if your insurance doesn't pay.** I understand that my insurance carrier may not cover some services and benefit information does not constitute approval of payment. Deductibles and Fees not paid by my insurance carrier will be my responsibility. Should collection become necessary, I further agree to pay \$2.00 every two weeks on balances over 60 days old. **Contact lens fit and follow up care is billed separately from your eye exam.** Your information is protected by our privacy policy.

I have received a copy of "Notice of Privacy Practices".

Remind me of my appointment by: Text

Signature _____ Date _____

Relationship to Patient _____