We're All Eyes!

Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your health.

Patient Information

Name ______ Last Name ______ First Name ______ Middle Initial ______ Soc. Sec. # ______

Address ______

City ______ State ______ Zip ______ Home Phone ______

Cell Phone ______ Email ______

Sex ☐ M ☐ F Age ______ Birthdate ______ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed by ______ Occupation ______

Business Address ______ Business Phone ______

Business Email ______

Whom may we thank for referring you? ______

Notify in case of emergency ______ Home Phone ______ Cell Phone ______

Business Phone ______ Email ______

Primary Insurance

Person Responsible for Account ______ Last Name ______ First Name ______ Middle Initial

Relation to Patient ______ Birthdate ______ Soc. Sec. # ______

Address (if different from patient) ______

City ______ State ______ Zip ______ Home Phone ______

Cell Phone ______ Email ______

Person Responsible Employed by ______ Occupation ______

Business Address ______ Business Phone ______

Business Email ______ Insurance Email ______

Insurance Company ______ Phone ______

Contract # ______ Group # ______ Subscriber # ______

Name(s) of other dependents under this plan ______

Additional Insurance

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name ______ Relation to Patient ______ Birthdate ______

Address (if different from patient) ______ Soc. Sec. # ______

City ______ State ______ Zip ______ Home Phone ______

Cell Phone ______ Email ______

Subscriber Employed by ______ Business Phone ______

Business Email ______ Insurance Email ______

Insurance Company ______ Phone ______

Contract # ______ Group # ______ Subscriber # ______

Name(s) of other dependents under this plan ______

Please complete both sides.

We're All Eyes!

Patient Visual and Health Information

What is the primary reason you have come in today? ____________________

Date of last visual exam ____________________ Doctor's name ____________________

Do you wear glasses now? ☐ Y ☐ N If yes, when and for what activities? ____________________

How old are your glasses? ____________________

Do you wear contact lenses now? ☐ Y ☐ N If yes, what type? ____________________

How old are your contact lenses? ____________________ What care system do you use? ____________________

Check (✓) yes or no whether your eyes are bothering you in the following ways:

☐Y ☐N Burning/Itching	☐Y ☐N Dizziness	☐Y ☐N Eye pain	☐Y ☐N Loss of sight
☐Y ☐N Change in vision	☐Y ☐N Double vision	☐Y ☐N Flaking lids	☐Y ☐N Perceptual difficulties
☐Y ☐N Contact lens difficulty	☐Y ☐N Dry eyes	☐Y ☐N Halos/Spots	☐Y ☐N Styes on lids
☐Y ☐N Discharge	☐Y ☐N Excess tearing	☐Y ☐N Light sensitivities	

List any work activities or hobbies you participate in that may require special visual needs: ____________________

____

Medical History

General health ____________________

Check (✓) yes or no whether you have had or currently have any of the following:

☐Y ☐N Allergies	☐Y ☐N Epilepsy	☐Y ☐N Headaches	☐Y ☐N Migraines
☐Y ☐N Arthritis, Rheumatism	☐Y ☐N Eye disease	☐Y ☐N High blood pressure	☐Y ☐N Pregnant
☐Y ☐N Blood disease	☐Y ☐N Glaucoma	☐Y ☐N Hypoglycemia	☐Y ☐N Sinusitis
☐Y ☐N Diabetes			

☐ Other ____________________

☐ Eye injuries What/when ____________________

☐ Eye surgery What/when ____________________

☐ General surgery What/when ____________________

List medications you are currently taking, if any:

____

____

List drug allergies, if any:

____

____

Any medications recently stopped/started ____________________

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the doctor to help determine appropriate treatment. If there is any change in my medical status, I will inform the doctor.

I authorize my insurance company to pay to the doctor or medical group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature ____________________ Date ____________________

Payment is due in full at time of treatment, unless prior arrangements have been approved.

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