

TELL US A LITTLE ABOUT YOURSELF...

To help our doctor better serve your specific needs, please answer the following questions as they apply to you.
PLEASE FILL IN ALL BLANKS! Thank you.

Male
 Female

Last Name First Name MI Preferred Name

Street Address City State Zip Code

Home Phone Daytime Phone Email Address

Social Security # Birth Date Account Responsibility if other than self

PRIMARY INSURANCE

Insurance Name _____
Group # _____
Insured's ID _____
Insured's Name _____
Insured's DOB _____
Insured's Employer _____

<p><u>How Did You Select Our Office?</u></p>

Patient Relationship to Insured **Patient Status** Single Married Other
 Self Spouse Child Other Full Time Student Part Time Student Employed

PRIMARY CARE PHYSICIAN

Name : _____
Phone _____

The Contact Lens Fitting/Evaluation Fee provides you with all of the diagnostic contact lenses needed for your prescription to be finalized. All follow-up appointments related to your contact lenses (up to three months) are inclusive with this fee. Professional Service Fees, including the examination charges and contact lens fitting fee, are Non-Refundable.

I have received a copy of the Health Privacy Act (HIPAA) information.

Note: Most insurance policies pay only a portion of your total charges. If you have questions about your coverage, please contact your representative. We **do not** guarantee the accuracy of benefit information given to us by insurance companies! I understand that I will be held responsible for the services I will be receiving. I further understand that payment is due at the time of services. In the event it becomes necessary to assign this account for collections or that any costs are incurred for collection of my past due account, I agree to be responsible for all costs of collection including a reasonable attorney fee. I authorize payment of medical benefits to the physician or supplier for services rendered.

Signed: _____ Date: _____

PATIENT HISTORY AND INFORMATION FOR

VISUAL HISTORY

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

CURRENT MEDICATIONS

DO YOU HAVE ANY DRUG ALLERGIES?

IF YES, MEDICATIONS THAT CAUSE REACTIONS OR SENSITIVITIES. _____

EYE HISTORY (Mark only those that apply)

Glaucoma	<input type="radio"/> Yes	Dryness	<input type="radio"/> Yes	Strabismus (Crossed Eyes)	<input type="radio"/> Yes
Cataract	<input type="radio"/> Yes	Excess Tearing/Watering	<input type="radio"/> Yes	Blurred Vision Distance	<input type="radio"/> Yes
Macular Degeneration	<input type="radio"/> Yes	Eye Pain or Soreness	<input type="radio"/> Yes	Blurred Vision Near	<input type="radio"/> Yes
Retinal Detachment	<input type="radio"/> Yes	Foreign Body Sensation	<input type="radio"/> Yes	Distorted Vision (habs)	<input type="radio"/> Yes
Color Blindness	<input type="radio"/> Yes	Infection of Eye or Lid	<input type="radio"/> Yes	Double Vision	<input type="radio"/> Yes
Headaches	<input type="radio"/> Yes	Itching	<input type="radio"/> Yes	Floaters or Spots	<input type="radio"/> Yes
Glare/ Light Sensitivity	<input type="radio"/> Yes	Mucous Discharge	<input type="radio"/> Yes	Fluctuating Vision	<input type="radio"/> Yes
Tired Eyes	<input type="radio"/> Yes	Drooping Eyelid	<input type="radio"/> Yes	Loss of Vision	<input type="radio"/> Yes
Amblyopia (Lazy Eye)	<input type="radio"/> Yes	Redness	<input type="radio"/> Yes	Loss of Side Vision	<input type="radio"/> Yes
Burning	<input type="radio"/> Yes	Sandy or Gritty Feeling	<input type="radio"/> Yes		

GENERAL HEALTH CONDITION

Fever	<input type="radio"/> Yes	Respiratory (Asthma)	<input type="radio"/> Yes	Anxiety or Depression	<input type="radio"/> Yes
Weight Loss	<input type="radio"/> Yes	Gastrointestinal	<input type="radio"/> Yes	Endocrine (Thyroid, Diabetes)	<input type="radio"/> Yes
Other Symptoms	<input type="radio"/> Yes	Kidney	<input type="radio"/> Yes	Blood/ Lymph	<input type="radio"/> Yes
Ears, Nose, Throat	<input type="radio"/> Yes	Muscles, Bones, Joints	<input type="radio"/> Yes	Allergic	<input type="radio"/> Yes
Cardiovascular (high blood pressure etc.)	<input type="radio"/> Yes	Skin	<input type="radio"/> Yes	Are you?	<input type="checkbox"/> Pregnant
		Neurological (Multiple Sclerosis)	<input type="radio"/> Yes		<input type="checkbox"/> Nursing

FAMILY HISTORY

Amblyopia (Lazy Eye)	<input type="radio"/> Yes	Retinal Detachment	<input type="radio"/> Yes	High Blood Pressure	<input type="radio"/> Yes
Blindness	<input type="radio"/> Yes	Strabismus (Eye Turn)	<input type="radio"/> Yes	Kidney Disease	<input type="radio"/> Yes
Cataract(s)	<input type="radio"/> Yes	Arthritis	<input type="radio"/> Yes	Lupus	<input type="radio"/> Yes
Color Blindness	<input type="radio"/> Yes	Cancer	<input type="radio"/> Yes	Stroke	<input type="radio"/> Yes
Glaucoma	<input type="radio"/> Yes	Diabetes	<input type="radio"/> Yes	Thyroid Disease	<input type="radio"/> Yes
Macular Degeneration	<input type="radio"/> Yes	Heart Disease	<input type="radio"/> Yes	Others	<input type="radio"/> Yes

WORK HISTORY

Current Occupation : _____ Employer : _____

SPECTACLE LENS HISTORY

Do you use a computer? Yes No
 Do you have glare problems? Yes No
 Do you have problems with night vision? Yes No
 Do you wear sunglasses? Yes No

CONTACT LENS HISTORY

Have you ever tried to wear contact lenses? Yes No Reason for stopping? _____
 Do you currently wear contact lenses? Yes No Since _____
 Type and brand of contact lenses _____
 How many hours/day? _____ How many days/week? _____
 Today's wearing time? _____

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

Hobbies/ Interests : _____