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Welcome To Our Office

Today's Date: _____
Last: _____ First: _____
Street: _____
City: _____ State: _____ Zip: _____
Home Phone: _____
Work Phone: _____
Social Security No.: _____
Employer (or School): _____
Occupation (or Grade): _____
Spouse (or Parents Name): _____
Spouse (or Parents Work): _____
Date of Birth: _____ Age: _____ Sex: M F
Email Address: _____ Can we contact you? _____
What is the major purpose of this visit? _____
Any problems with your present contact lenses or glasses? _____

VERY IMPORTANT! NEW PATIENTS ONLY:

Who may we thank for referring you to our office?
Name of friend or relative: _____
If not referred, how did you choose our office for your needs?
 Other Doctor Insurance List
 Saw sign or building Newspaper/Radio/TV
 Yellow Pages, Which Directory? _____
 Web Page, Which Site? _____
 Other: _____

Insurance Information

Vision Insurance: _____
Subscriber Name: _____
Subscriber SSN: _____
Subscriber Birth Date: _____
Primary Medical Insurance: _____
Subscriber Name: _____
Subscriber SSN: _____
Subscriber Birth Date: _____
Do you participate in a flex spending account: Yes No
How will you settle your account today?
 Cash Check Credit Card

Family Medical/Eye History

Is there a family medical history of any of the following?
Relationship

Blindness:	<input type="checkbox"/>	_____
Cataracts:	<input type="checkbox"/>	_____
Corneal Problems	<input type="checkbox"/>	_____
Glaucoma:	<input type="checkbox"/>	_____
Lazy Eye:	<input type="checkbox"/>	_____
Macular Degeneration:	<input type="checkbox"/>	_____
Retinal Problems:	<input type="checkbox"/>	_____
Diabetes:	<input type="checkbox"/>	_____

The information in this confidential case history form is critical to the evaluation of your vision and health.

Patient Medical History

Name of Family Physician: _____
Town: _____
Date of Last Physical Check-up: _____

CURRENT MEDICATIONS (Rx or Over the counter)
(List name of medications including eye drops, vitamins & Birth control pills) _____

Allergies to Medications: Yes No

Have you ever been diagnosed or treated for the following?

<input type="checkbox"/> Allergies	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Thyroid
<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Other _____
<input type="checkbox"/> Arthritis	<input type="checkbox"/> High Blood Pressure	_____
<input type="checkbox"/> Cancer	<input type="checkbox"/> Kidneys	_____
<input type="checkbox"/> Cholesterol	<input type="checkbox"/> Nerves	_____

Patient Eye History

Date of last eye exam? _____
By Whom? _____
Do you currently wear contact lenses? Yes No
What Kind? _____
Solutions Used? _____
Would you prefer clear contact lenses, or colored contact lenses to change the color of your eyes? Clear Colored.
Have you ever tried contact lenses? Yes No

Do You.....(Check box if your answer is yes)

Work at a computer?
 Think you might benefit from thinner, lighter lenses?
 Have an interest in a "Test Drive" of the latest contact designs?
 Spend time outdoors? _____ hrs/wk
 Have prescription sunglasses?
 Prefer not to wear your glasses at times?
 Want information on Laser Vision Correction surgery?
 Have interest in a non-surgical vision correction?
 Have more than 1 pair of current Rx glasses?
 Have children?
 Have other family members in need of eye care?
If you wear bifocals, are you bothered by the lines or head tilting Yes No
If you wear contact lenses, are you satisfied with the vision and comfort Yes No

Have you ever been diagnosed or treated for the following?

<input type="checkbox"/> Cataracts	<input type="checkbox"/> Iritis/Uveitis
<input type="checkbox"/> Corneal Abrasion	<input type="checkbox"/> Lazy eye
<input type="checkbox"/> Eye infection	<input type="checkbox"/> Macular Degeneration
<input type="checkbox"/> Eye injury	<input type="checkbox"/> Retinal Detachment
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Other eye disorders

Do you experience or have you ever experienced?

<input type="checkbox"/> Blurry Vision	<input type="checkbox"/> Flash of Light	<input type="checkbox"/> Sunlight Sensitivity
<input type="checkbox"/> Burning	<input type="checkbox"/> Floaters/Spots	<input type="checkbox"/> Tearing
<input type="checkbox"/> Crossed eye/eye turn	<input type="checkbox"/> Grittiness	<input type="checkbox"/> Poor night vision
<input type="checkbox"/> Double Vision	<input type="checkbox"/> Headaches	<input type="checkbox"/> Uncomfortable Glasses
<input type="checkbox"/> Occasional Dryness	<input type="checkbox"/> Itchiness	