eyecare focused on you

Date: _____

Patient Name: _____ (Last) _____ (First) _____ (M.I.) **Sex:** M F

Address: _____ (Number & Street) _____ (City & State) _____ (Zip Code)

Phone: (___) _____ (Home) (___) _____ (Work) (___) _____ (Cell)

Email: _____ **Preferred Method of Contact:** __Cell Phone __Home Phone __Work Phone

SSN: XXX - XX - _____ **Age:** _____ **Date of birth** ___/___/___ (Mo. / Day / Yr.) **Spouse Name:** _____

Your Employer: _____ **Occupation:** _____

Primary Language: _____

Emergency Contact: _____ (___) _____ (Phone) _____ (Relationship to Patient)

Race: Check one ❑ **American Indian or Alaskan Native** ❑ **Asian** ❑ **Black or African American**
❑ **Native Hawaiian or Other Pacific Islander** ❑ **White** ❑ **Decline to Specify**

Ethnicity: Check one ❑ **Hispanic or Latino** ❑ **Not Hispanic or Latino** ❑ **Decline to Specify**

Do you have vision insurance? **VSP** ❑ **Superior** ❑ **Medicare** ❑ **EyeMed** ❑ **Cigna Vision** ❑ **Davis** ❑

Has any household member been a patient here? Y / N **Name(s)** _____

Responsible Party/Policy Holder Information: _____ (Last) _____ (First) _____ (M.I.)

DOB _____ **SSN: XXX - XX -** _____

Would you permit dilation of your eyes if requested Y N _____ (please initial)

Have you ever had an allergic reaction to any medication or anesthesia? Y N if so, which one(s) _____

Services Requested today: _____ Vision Analysis/Eye Exam _____ Contact Lens Eval./Fitting

Urgent Care Services: _____ Eye Disease/Infection _____ Eye Injury _____ Foreign Body Injury

Other: _____

Vision History

Do You Currently Have Glasses? Yes / No Age of Glasses?_____ Do You Wear Contacts? Yes / No Type _____

Last Eye Exam? _____ Name of Eye Doctor _____

Review Of Systems / Medical History (circle all that apply)

Have you ever had or do you have any of the following:

Yes / No Allergies (seasonal hayfever)
Yes / No Cardiovascular Disease (hypertension, chest pain, etc.)
Yes / No Endocrine disease (diabetes, thyroid, etc.)
Yes / No Genitourinary (kidney, bladder, etc.)
Yes / No Immunologic (immune disease, AIDS, etc.)
Yes / No Neurologic (headaches, migraines, seizure, etc.)
Yes / No Respiratory (asthma, emphysema, etc.)
Yes / No Other Health Problems _____

Yes / No Ear, Nose, Throat (hearing loss, sore throat)
Yes / No Constitutional (fever, fatigue, weight change, etc.)
Yes / No Gastrointestinal (ulcers, reflux, liver disease, etc.)
Yes / No Hematological/Lymphatic (anemia, leukemia, bleeding)
Yes / No Musculoskeletal (arthritis, neck, back, etc.)
Yes / No Psychiatric (depression, anxiety, etc.)
Yes / No Skin/Breast (rash, growths, cancer, etc.)

List Medications Currently Taking and Condition for Which Prescribed

_____

Name of Family Physician _____ Last Physical Exam _____

Ocular Health History

Do You Have..
Yes / No___ Color Vision Defect
Yes / No___ Dry Eyes
Yes / No___ Corneal Disease
Yes / No___ Cataracts
Yes / No___ Glaucoma
Yes / No___ Retinal Detachment
Yes / No___ Macular Degeneration
Yes / No___ Eye Turning
Yes / No___ Double Vision

Other _____

Ocular Medications

List All Eye Medications You Are Currently Using

_____
_____
_____
_____

Family Ocular History

Any family members with.. Relationship
Yes / No___ Color vision defect
Yes / No___ Dry Eyes
Yes / No___ Corneal Disease _____
Yes / No___ Cataracts
Yes / No___ Glaucoma _____
Yes / No___ Retinal Detachment
Yes / No___ Macular Degeneration _____
Yes / No___ Eye Turn
Yes / No___ Double Vision _____

Other _____

Have You Had Eye Surgery or Eye Injuries? Explain and Give Dates _____

Social History

Do You Smoke? Yes / No Frequency _____
Do You Drink Alcohol Yes / No Frequency _____
Do You Use Drugs? Yes / No Frequency _____

Please continue and sign the back of this form

How Did You Learn About Our Office: ___Family ___Friend ___Coworker ___Physician Referral ___Insurance ___Phone Book ___Other: _____

General Office Policies and Acknowledgement of Receipt

Eyeglasses: By signing, I agree to the following: If there are any adaptation problems with my new prescription an appointment needs to be made within 30 days from the date of dispense. I understand there is no refund or credit for any downgrades made to my lenses after ordering. I understand that I am responsible for the cost of new lenses after 30 days from the date of dispense. I understand that Contact Lens Associates is not responsible for patient's own frames and will not give credit for patient own frames damaged or broken during the re-lensing process.

Contact lenses: By signing, I agree to the following: I am responsible for paying a fitting fee that does not include the cost of my contact lenses. Since I have agreed to start the fitting process, I am responsible for making any necessary appointments to finalize my prescription. I understand that the fitting process may require more than 3 visits. I am responsible for any new charges for any visits after 90 days. If I am unable to wear contact lenses after the fitting process, or if I choose to stop the fitting process, I understand my fitting fee is non refundable and no credit will be issued. Any contacts returned will be subject to a restocking fee.

HIPAA Privacy Notice: By Signing, I understand and acknowledge the office Privacy Practice Notice and it has been made available to me.

Patient Name (please print): _____

Signature: _____ Date: _____