

Today's Date _____

WELCOME TO OUR OFFICE

Patient Information

Last _____
 First _____ MI _____
 Street _____
 City _____ State _____
 Zip Code _____
 PHONE: Home _____ Cell _____
 Work _____
 Email Address _____
 Patient's SSN _____
 Employer (or School) _____
 Occupation (or Grade) _____
 Date of Birth _____ Sex M F
 Ethnicity: white asian African-american hispanic
 american indian
 Spouse (or Parent's Name) _____
 Spouse (or Parent's Work) _____

What is the major purpose of this visit?

Any problems with your current contact lenses or glasses?

Our Mission Is To:

- *Provide the most complete, thorough, innovative vision care, both today and for your lifetime.*
- *Inspire your confidence in us by pledging to meet your every expectation for your care.*
- *Honor the trust you've placed in us by proactively protecting your visual health.*
- *Treat you with the consideration, caring and courtesy you deserve.*
- *Constantly strive for the best in eye health care through continuing education of staff and patients.*

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

Lifestyle Questions

Do you.....(check box if your answer is yes)

- ..work at a computer? _____ hrs/day _____ days/wk
- ..think you might benefit from thinner, lighter lenses?
- ..have interest in trying the latest contact lens designs
- ..spend time outdoors? How much? _____ Hrs/week
- ..have prescription sunwear?
- ..prefer not to wear your glasses at times?
- ..want information on Laser Vision Correction surgery?
- ..have children?
- ..have family members in need of eyecare?
- ..have hobbies with special vision requirements?

..play sports? Which ones? _____

Have you ever experienced, been diagnosed or treated for any of the following?

- | | |
|--|--|
| <input type="checkbox"/> Blurry Vision | <input type="checkbox"/> Burning |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Changing Focus |
| <input type="checkbox"/> Crossed eye/Eye turn | <input type="checkbox"/> Double Vision |
| <input type="checkbox"/> Eye Infections | <input type="checkbox"/> Eye Injury |
| <input type="checkbox"/> Flash of light | <input type="checkbox"/> Floaters/Spots |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Grittiness |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Iritis/Uveitis |
| <input type="checkbox"/> Itchiness | <input type="checkbox"/> Lazy Eye |
| <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Occasional dryness |
| <input type="checkbox"/> Retinal Detachment | <input type="checkbox"/> Sunlight Sensitivity |
| <input type="checkbox"/> Tearing | <input type="checkbox"/> Trouble seeing at night |
| <input type="checkbox"/> Other eye disorders _____ | |

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

Patient Medical History		
Family Physician (Pediatrician) _____		
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? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If so, what medications? _____		

Have you had any surgeries? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Do you use cigarettes/tobacco, alcohol, or other substances? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Have you ever been diagnosed or treated for the following health problems?		
	Yes	No
Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Blood/Lymph	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Digestive	<input type="checkbox"/>	<input type="checkbox"/>
Ears/Nose/Throat	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine	<input type="checkbox"/>	<input type="checkbox"/>
Eczema/Rashes	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>
Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Integumentary (Skin)	<input type="checkbox"/>	<input type="checkbox"/>
Kidney	<input type="checkbox"/>	<input type="checkbox"/>
Muscle/Bone	<input type="checkbox"/>	<input type="checkbox"/>
Neurological	<input type="checkbox"/>	<input type="checkbox"/>
Psychological	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>
Sinus	<input type="checkbox"/>	<input type="checkbox"/>
Throat Infections	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Unusual weight losses/gains	<input type="checkbox"/>	<input type="checkbox"/>

Patient Eye History	
Date of Last Eye Exam _____	
By Whom? _____	
Have you ever tried contact lenses?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you currently wear contact lenses?	<input type="checkbox"/> Yes <input type="checkbox"/> No
What kind? _____	
Solutions used _____	
Are you satisfied with the vision and comfort of your contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Would you prefer clear contact lenses or colored contact lenses? <input type="checkbox"/> Clear <input type="checkbox"/> Colored <input type="checkbox"/> Both	
If you wear bifocals, do the lines or head tilting bother you? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Family Medical/Eye History (Check all that apply)	
Is there a family medical history of any of the following: <input type="checkbox"/> No <input type="checkbox"/> Yes (Please check boxes)	
	Relationship
Blindness	<input type="checkbox"/> _____
Cataracts	<input type="checkbox"/> _____
Corneal Problems	<input type="checkbox"/> _____
Diabetes	<input type="checkbox"/> _____
Glaucoma	<input type="checkbox"/> _____
Heart Disease	<input type="checkbox"/> _____
Lazy Eye	<input type="checkbox"/> _____
Macular Degeneration	<input type="checkbox"/> _____
Retinal Problems	<input type="checkbox"/> _____

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?

Another Dr.

Insurance List

Saw Sign/Building

Newspaper: Which one? _____

Magazine: Which one? _____

Web Page: Which Web Site? _____

Other _____

Our Doctors and Staff Want You to Know How We Will Protect Your Family's Private Health Information.

When you visit our office it is very important that you feel safe in telling our providers and staff personal information that may be required to fully diagnose or treat the problem. As medical professionals, please be assured that our practice has always had strict policies and procedures to protect the confidentiality of the information that you have entrusted to us. However on April 14, 2003, new regulations became effective under federal law called the Health Insurance Portability and Accountability ACT ("HIPPA").

The new HIPPA rules include:

Protection of all individually identifiable health information, whether maintained or transmitted on paper, or in electronic format.

Includes any information, including demographic data that permits identification of the individual or could reasonably be used, alone or in combination with other available information, to identify the individual created or received by the "covered entity".

Please sign below that we have notified you of the new Privacy Practices.

Thank you for your cooperation.

Patient Name: _____
(Please Print)

Signature of Patient/Parent/Guardian/Personal Representative

_____ Date: _____

Relationship to Patient: _____