Welcome Back To Our Office!

Today's Date _____

Patient Information

Last_____
First_____ MI _____
Street_____
City_____ State _____
Zip Code _____
Home Phone_____
Work Phone _____
SSN(Last 4) _____
Employer (or School) _____
_____
Occupation (or Grade) _____
_____
Spouse (or Parent's Name) _____
_____
Date of Birth _____
Sex M F
Email Address _____

What is the main purpose of this visit?
_____

Any problems with your current contact lenses or glasses?
_____
_____

Insurance Information

Vision Insurance _____
_____
Subscriber Name _____
SSN(Last 4) _____
Subscriber Birth Date _____

Primary Medical Insurance _____
_____
Subscriber Name _____
SSN(Last 4) _____
Subscriber Birth Date _____

Do you participate in a flex spending account? Y or N
How will you settle your account today?
Cash Check Credit Card

Lifestyle Questions

Do You……..(put "x" on the line if yes)

____ work at a computer? ___ hours
___ spend time outdoors?___hrs/wk
___ have prescription sun wear or nonprescription sun wear?
___ interested in Laser Vision Correction?
___ interested in a non-surgical approach to vision correction?
___ have children?
___ have family in need of eye care?

Have you ever experienced, been diagnosed or treated for any of the following?(circle if yes)**blurry vision, cataracts, corneal abrasion, tearing, burning crossed eye, double vision, lazy eye eye injury, flash of light, headaches sun sensitivity, dryness, Itchiness macular degeneration, glaucoma, retinal detachment, grittiness, eye infections**

Patient Medical History

Name of Family Physician _____
Town _____
Date of Last Physical Check-Up _____

Current Medications (Rx or OTC)
(List name of medications including eye drops, vitamins, and birth control)_____
_____
_____

Allergies to medications? Y / N
If so, what medications? _____
_____

Have you had any surgeries? Y / N

Do you use cigarettes/tobacco, alcohol, or other substances? Y / N

	Yes	No
Allergies	__	__
Arthritis	__	__
Blood/Lymph	__	__
Bronchitis	__	__
Cancer	__	__
Cholesterol	__	__
Diabetes	__	__
Digestive	__	__
Ears/Nose/Throat	__	__
Endocrine	__	__
Eczema/Rashes	__	__
Fatigue	__	__
Fevers	__	__
Genitourinary	__	__
High Blood Pressure	__	__
Integumentary(skin)	__	__
Kidney	__	__
Muscle/Bone	__	__
Neurological	__	__
Psychological	__	__
Respiratory	__	__
Sinus	__	__
Throat Infections	__	__
Thyroid	__	__
Weight loss/gains	__	__

Patient Eye History

Date of Last Eye Exam _____
By Whom? _____

Have you ever tried contact lenses? Y / N

Do you currently wear contact lenses? Y / N
What kind? _____
Solutions used _____

Are you satisfied with the vision and comfort of your contact lenses? Y / No

Would you prefer clear contact lenses or colored contact lenses? __Clear __Colored

If you wear bifocals, do the lines or head tilting bother you? Y / N

Family Medical/Eye History (Check all that apply)

	Relationship (Mother's or Father's side)
Blindness	_____
Cataracts	_____
Corneal Problems	_____
Diabetes	_____
Glaucoma	_____
Heart Disease	_____
Lazy Eye	_____
Macular Degeneration	_____
Retinal Problems	_____

Please be advised if you are using insurance coverage for today's visit, this is a contract between you and your insurance company. Not True Eye Care.

If your insurance company has not reimbursed our office office in full within 90 days, your credit card will be utilized and your insurance company will then pay you directly. (If by mistake your insurance company sends the payment check to us, we will of course sign over and forward the check directly to you.)
CC#_____Exp. Date _____
Signature_____