

Patient Information
Last _____
First _____ MI _____
Street _____
City _____ State _____
Zip Code _____
Home Phone _____
Work Phone _____
Date of Birth _____
Patient's SSN _____
Employer (or School) _____
Occupation (or Grade) _____
Spouse (or Parent's Name) _____
Spouse (or Parent's Work) _____
Sex M F
Email Address _____
Whom may we thank for referring you to our office? _____

Insurance Information
<i>Please note that insurance does NOT cover the Contact Lens Evaluation.</i>
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? <input type="checkbox"/> Yes <input type="checkbox"/> No
How will you settle your account today? <input type="checkbox"/> Cash <input type="checkbox"/> Check <input type="checkbox"/> Credit Card
Please be advised if you are using insurance coverage for today's visit, this is a contract between you and your insurance company...not Eyecare Associates.
If your insurance company has not reimbursed our office in full within 90 days, your credit card will be utilized and your insurance company will then pay you directly.
Please enter your credit card number and expiration. CC#: _____
Expiration Date: _____
Signature: _____

*It is the mission of Eyecare Associates to provide the highest quality of health care available with an emphasis on ocular wellness and prevention.*

*We are dedicated to remain at the forefront of our profession by seeking continued education and by utilizing advancements in technology to improve the care we provide.*

*Our patients deserve personal attention, exceptional services and our commitment to the highest ethical standards.*

Lifestyle Questions
<b>Do you.....(check box if your answer is yes)</b>
<input type="checkbox"/> ..work at a computer? If yes, please complete computer questionnaire.
<input type="checkbox"/> ..think you might benefit from thinner, lighter lenses?
<input type="checkbox"/> ..have interest in a "test drive" of the latest contact lens designs
<input type="checkbox"/> ..spend a lot of time outdoors?
<input type="checkbox"/> ..have prescription sunwear?
<input type="checkbox"/> ..want information on Laser Vision Correction surgery?
<input type="checkbox"/> ..have interest in a non-surgical approach to vision correction?
<input type="checkbox"/> ..have more than 1 pair of current Rx eyewear?
<input type="checkbox"/> ..have children?
<input type="checkbox"/> ..have family members in need of eyecare?

Office Use Only:
Reviewed Date: _____
Reviewed Date: _____
Reviewed Date: _____
Reviewed Date: _____
Reviewed Date: _____

Patient Name: \_\_\_\_\_

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 _____	
<b>CURRENT MEDICATIONS (Rx or Over the Counter)</b> (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? _____ _____	
Do you use alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you use cigarettes/tobacco, or other substances? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Have you ever been diagnosed or treated for the following health problems?</b> (check/circle all that apply)	
<input type="checkbox"/> <b>Cancer:</b> Lung, Breast, Stomach, Colon, Liver, Prostate, Skin	
<input type="checkbox"/> <b>Cardiac:</b> Heart attack, Arrhythmia, Valve, CHF, Bypass, Pacemaker	
<input type="checkbox"/> <b>Vascular:</b> High blood pressure, Cholesterol, Carotid artery	
<input type="checkbox"/> <b>Blood:</b> Anemia, Bleeding problems, Leukemia, Clots	
<input type="checkbox"/> <b>Pulmonary:</b> Asthma, Emphysema, COPD, Bronchitis, TB, Sleep Apnea	
<input type="checkbox"/> <b>Neuro:</b> Migraine/HA, Stroke, Seizures, Tumor, MS, Parkinsons, Alzheimer's	
<input type="checkbox"/> <b>Genitourinary:</b> Kidney Failure, Dialysis, Stones	
<input type="checkbox"/> <b>Endocrine:</b> Diabetes, Thyroid, Adrenal, Graves	
<input type="checkbox"/> <b>Digestive:</b> Ulcers, Hepatitis, Colitis, Acid Reflux	
<input type="checkbox"/> <b>Immune:</b> Lupus, Fibromyalgia, HIV, Aids	
<input type="checkbox"/> <b>Bones/Muscles:</b> Arthritis, Rheumatoid Arthritis	
<input type="checkbox"/> <b>Skin:</b> Psoriasis, Eczema, Rashes, Shingles	
<input type="checkbox"/> <b>ENT:</b> Sinusitis, Allergies, Vertigo, Hay fever	
<input type="checkbox"/> <b>Emotional:</b> Depression, Bipolar, ADHD	
<input type="checkbox"/> <b>Developmental:</b> Premature, Complicated delivery, Birth defect	
<input type="checkbox"/> <b>Constitutional:</b> Weight loss, fatigue, fever	
<input type="checkbox"/> <b>None of the above apply</b>	

Patient Eye History	
Date of Last Eye Exam _____ By Whom? _____	
<b>Have you ever experienced, been diagnosed or treated for any of the following?</b>	
<input type="checkbox"/> Blurry Vision	<input type="checkbox"/> Burning
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Corneal Abrasions
<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 _____	
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 (Mother's or Father's side)
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"/> _____

You are financially responsible for all charges not paid by your insurance company. If your insurance company has not reimbursed our office in full within 90 days, your credit card will be utilized and your insurance company will pay you direct.

I consent to examination, treatment and procedures which may be performed during office visits including emergency treatment considered necessary by the physician and/or his designated providers.

I understand that I am financially responsible for all charges whether or not paid by my insurance. I understand that should I default on payment of my account and collection agency services are required, all costs of collection including attorney fees will be added to the balance of my account.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_