

**TELL US A LITTLE ABOUT YOURSELF...**

To help our doctor better serve your specific needs, please answer the following questions as they apply to you.  
**PLEASE FILL IN ALL BLANKS! Thank you.**

Male  
 Female

\_\_\_\_\_  
Last Name                      First Name                      MI                      Preferred Name

\_\_\_\_\_  
Street Address                      City                      State                      Zip Code

\_\_\_\_\_  
Home Phone                      Daytime Phone                      Email Address

\_\_\_\_\_  
Social Security #                      Birth Date                      Account Responsibility if other than self

**PRIMARY INSURANCE**

Insurance Name \_\_\_\_\_  
Group # \_\_\_\_\_  
Insured's ID \_\_\_\_\_  
Insured's Name \_\_\_\_\_  
Insured's DOB \_\_\_\_\_  
Insured's Employer \_\_\_\_\_

How Did You  
Select Our Office?

**Patient Relationship to Insured**

Self    Spouse    Child    Other

**Patient Status**

Full Time Student    Single    Married    Other  
 Part Time Student    Employed

**PRIMARY CARE PHYSICIAN**

Name \_\_\_\_\_

Phone \_\_\_\_\_

The Contact Lens Fitting/Evaluation Fee provides you with all of the diagnostic contact lenses needed for your prescription to be finalized. All follow-up appointments related to your contact lenses (up to three months) are inclusive with this fee. Professional Service Fees, including the examination charges and contact lens fitting fee, are Non-Refundable.

*I have received a copy of the Health Privacy Act (HIPAA) information.*

Note: Most insurance policies pay only a portion of your total charges. If you have questions about your coverage, please contact your representative. We do not guarantee the accuracy of benefit information given to us by insurance companies! I understand that I will be held responsible for the services I will be receiving. I further understand that payment is due at the time of services. In the event it becomes necessary to assign this account for collections or that any costs are incurred for collection of my past due account, I agree to be responsible for all costs of collection including a reasonable attorney fee. I authorize payment of medical benefits to the physician or supplier for services rendered.

Signed: \_\_\_\_\_

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

# PATIENT HISTORY AND INFORMATION FOR

## VISUAL HISTORY

What is the main reason for today's exam? \_\_\_\_\_ When was your last exam? \_\_\_\_\_

## CURRENT MEDICATIONS \_\_\_\_\_

## PLEASE LIST MEDICATIONS THAT YOU ARE ALLERGIC TO \_\_\_\_\_

### EYE HISTORY (Mark only those that apply)

Glaucoma	<input type="checkbox"/> Yes	Dryness	<input type="checkbox"/> Yes	Strabismus (Crossed Eyes)	<input type="checkbox"/> Yes
Cataract	<input type="checkbox"/> Yes	Excess Tearing/Watering	<input type="checkbox"/> Yes	Blurred Vision Distance	<input type="checkbox"/> Yes
Macular Degeneration	<input type="checkbox"/> Yes	Eye Pain or Soreness	<input type="checkbox"/> Yes	Blurred Vision Near	<input type="checkbox"/> Yes
Retinal Detachment	<input type="checkbox"/> Yes	Foreign Body Sensation	<input type="checkbox"/> Yes	Distorted Vision (halos)	<input type="checkbox"/> Yes
Color Blindness	<input type="checkbox"/> Yes	Infection of Eye or Lid	<input type="checkbox"/> Yes	Double Vision	<input type="checkbox"/> Yes
Headaches	<input type="checkbox"/> Yes	Itching	<input type="checkbox"/> Yes	Floaters or Spots	<input type="checkbox"/> Yes
Glare/Light Sensitivity	<input type="checkbox"/> Yes	Mucous Discharge	<input type="checkbox"/> Yes	Fluctuating Vision	<input type="checkbox"/> Yes
Tired Eyes	<input type="checkbox"/> Yes	Drooping Eyelid	<input type="checkbox"/> Yes	Loss of Vision	<input type="checkbox"/> Yes
Amblyopia (Lazy Eye)	<input type="checkbox"/> Yes	Redness	<input type="checkbox"/> Yes	Loss of Side Vision	<input type="checkbox"/> Yes
Burning	<input type="checkbox"/> Yes	Sandy or Gritty Feeling	<input type="checkbox"/> Yes		

## GENERAL HEALTH CONDITION

Fever	<input type="checkbox"/> Yes	Respiratory (Asthma)	<input type="checkbox"/> Yes	Anxiety or Depression	<input type="checkbox"/> Yes
Weight Loss	<input type="checkbox"/> Yes	Gastrointestinal	<input type="checkbox"/> Yes	Endocrine (Thyroid, Diabetes)	<input type="checkbox"/> Yes
Other Symptoms	<input type="checkbox"/> Yes	Kidney	<input type="checkbox"/> Yes	Blood/Lymph	<input type="checkbox"/> Yes
Ears, Nose, Throat	<input type="checkbox"/> Yes	Muscles, Bones, Joints	<input type="checkbox"/> Yes	Allergies	<input type="checkbox"/> Yes
Skin	<input type="checkbox"/> Yes	Neurological (Multiple Sclerosis)	<input type="checkbox"/> Yes	Are You?	<input type="checkbox"/> Pregnant <input type="checkbox"/> Nursing
<input type="checkbox"/> Smoking <input type="checkbox"/> Chewing		Blood pressure/Heart Disease	<input type="checkbox"/> Yes		

## FAMILY HISTORY

Amblyopia (Lazy Eye)	<input type="checkbox"/> Yes	Retinal Detachment	<input type="checkbox"/> Yes	High Blood Pressure	<input type="checkbox"/> Yes
Blindness	<input type="checkbox"/> Yes	Strabismus (Eye Turn)	<input type="checkbox"/> Yes	Kidney Disease	<input type="checkbox"/> Yes
Cataract(s)	<input type="checkbox"/> Yes	Arthritis	<input type="checkbox"/> Yes	Lupus	<input type="checkbox"/> Yes
Color Blindness	<input type="checkbox"/> Yes	Cancer	<input type="checkbox"/> Yes	Stroke	<input type="checkbox"/> Yes
Glaucoma	<input type="checkbox"/> Yes	Diabetes	<input type="checkbox"/> Yes	Thyroid Disease	<input type="checkbox"/> Yes
Macular Degeneration	<input type="checkbox"/> Yes	Heart Disease	<input type="checkbox"/> Yes	Others	<input type="checkbox"/> Yes

## WORK HISTORY

Current Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

## SPECTACLE LENS HISTORY

Do you use a computer?  Yes  No Do you have problems with night vision?  Yes  No  
Do you have glare problems?  Yes  No Do you wear sunglasses?  Yes  No  
Are You Interested In Purchasing Glasses Today?  Yes  No

## CONTACT LENS HISTORY

Have you ever tried to wear contact lenses?  Yes  No Reason for stopping? \_\_\_\_\_  
Do you currently wear contact lenses?  Yes  No Brand of contact lenses \_\_\_\_\_  
How many hours/day? \_\_\_\_\_ How many days/week? \_\_\_\_\_  
Today's wearing time? \_\_\_\_\_  
If you are not a contact lens wearer, are you interested in trying contact lenses at this time?  Yes  No  
Are you interested in Lasik surgery?  Yes  No

## HOBBIES/INTERESTS: \_\_\_\_\_