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Patient Personal Information

First Name _____ MI _____ Employer _____
 Last Name _____ Occupation _____
 Address _____ Home Phone _____
 City _____ Work Phone _____
 State _____ Zip _____ Cell Phone _____
 Date of Birth ____ / ____ / ____ Parent/Guardian _____
 Sex: M / F Marital Status: S / M / D / W Emergency Contact _____
 Emergency Phone _____

Primary Care Doctor: _____

Pharmacy w/City Location: _____

E-MAIL & TEXT NOTIFICATIONS

- On-line Appointment Requests
- Text Notifications of Completed Orders
- Appointment Confirmations
- Text Message Appointment Reminders
- Satisfaction Surveys

Please provide information below so that we are better able to service you and your eye care needs!

Email: _____ **Cell:** _____

Patient Insurance Information: Relationship to Insured: Self Spouse Child

Medical Ins. Carrier _____	Vision Hardware Plan _____
ID# _____	ID# _____
Group # _____	Group # _____
Policy Holder's Name _____	Policy Holder's Name _____
Policy Holder's DOB ____ / ____ / ____	Policy Holder's DOB ____ / ____ / ____
Policy Holder's SSN ____ - ____ - ____	Policy Holder's Last 4 of SSN ____ & Zip _____

Patient Medical History Name: _____ DOB: _____

What is the main purpose of this visit? _____ Year of last eye examination: _____

Were your eyes dilated at your last exam? yes no

Have you ever had a dilated exam? yes no

Are you Pregnant? yes no

Are you Nursing? yes no

Are you a Contact Lens Wearer? yes no

Have you had LASIK/PRK surgery? yes no
Dr's Name: _____
Date of Surgery: _____
Are you interested in LASIK? yes no

Brand Name _____

Right Eye Rx _____ Left Eye Rx _____
(include BC & DIA parameters) (include BC & DIA parameters)

List all allergies (environmental or drug): _____

Current medications or supplements: _____

Do you have Diabetes? yes no
 Type I Type II

Year diagnosed: _____

Last HbA1C: _____

Do you/have you ever used tobacco products? yes no
Type: _____ Amount: _____ How long? _____

Do you drink alcohol? yes no

Type: _____ Amount: _____ How long? _____

Have you ever been diagnosed/treated for the following?

- Cataracts yes no
- Glaucoma yes no
- Macular Degeneration yes no
- Retinal Detachment yes no
- Lazy Eye or Eye Turn yes no
- Eye Injury yes no
- Eye Surgery yes no

If yes, provide details: _____

Do you experience any of the following?

- Blurry Vision yes no
If so: distance: near both
- Difficulty at computer yes no
- Difficulty driving at night yes no
- Dry Eye yes no
- Headaches yes no
- Double Vision yes no
- Flashes of Light yes no
- Persistent Floaters yes no
- Eye Itching yes no
- Eye Tearing yes no

Have you ever been diagnosed or treated for any of the following problems? *Explanation of Problem*

- Endocrine (thyroid, hormones, glands) yes no _____
- Cardiovascular (heart, blood vessels) yes no _____
- High Blood Pressure yes no _____
- Respiratory (lungs, breathing) yes no _____
- Gastrointestinal (stomach, intestines) yes no _____
- Musculoskeletal (muscles, joints, arthritis) yes no _____
- Integument (skin) yes no _____
- Neurological (migraines, seizures) yes no _____
- Psychiatric (anxiety, depression, etc) yes no _____
- Ears, Nose, Mouth, Throat yes no _____
- Hematologic/Lymphatic (anemia, etc) yes no _____
- Allergic/Immunologic yes no _____
- HIV/AIDS yes no _____

Do you have a family medical history of the following:

Glaucoma yes no Relationship: _____ (Maternal or Paternal)
Lazy Eye yes no Relationship: _____ (Maternal or Paternal)
Macular Degeneration yes no Relationship: _____ (Maternal or Paternal)
Color Blindness yes no Relationship: _____ (Maternal or Paternal)
Other Vision History _____

Preferred Language: English
 Spanish

Race: *(Please indicate all that apply)* White
 American Indian or Alaskan Native
 Asian
 African American
 Hispanic
 Native Hawaiian or Pacific Islander

Ethnicity: Not Hispanic or Latino
 Native Hawaiian/ Other Pacific Islander

Communication Preference: Email
 Text
 Mail
 Telephone

Referred by: Patient: _____ Professional: _____ Other: _____

Contact Lens Management (for current wearers only): For your health and safety, we perform annual contact lens evaluations. A separate contact lens fee is charged beyond the comprehensive eye examination. We determine fit, health and the condition of the eyes while wearing contact lenses. We also evaluate changes in prescription and lens design during this process. **Soft contact lens evaluation and new prescription is \$35; refitting to a new brand of contact lens will cost between \$85 and \$199, depending on the type of lens being fit. The fees for Custom or RGP contact lens evaluations and refits will vary. Please ask the Staff or your Optometrist for details.**

Financial Responsibility & Benefits Coverage: I understand that the doctor(s) may or may not be participating with my insurance carrier and I am fiscally responsible for all charges whether or not paid by my insurance company. I give my permission to bill my insurance company with the understanding that I am responsible for all charges whether or not paid by my insurance carrier. I understand that I am responsible for and aware of my eyewear benefits coverage and it is my responsibility to make that information known at time of purchase. I understand that I will forfeit such benefits if they are provided after merchandise has been completed and/or provided. I understand that **the fee for returned checks is \$50.00, and the fee for a missed or cancelled appointment without 24-hour notice is \$50.00.**

Please sign below that you have reviewed all of the information above and it is correct to the best of your knowledge.

Signature _____ Printed Name _____ Date _____
(Required)