WELCOME TO OUR OFFICE

Full Name_____ Today's Date_____
Date of Birth_____Age___ Marital Status: Single Married Div Sep Widow
Mailing Address_____ City_____Zip_____
Occupation_____ Employer_____
Cell Phone # _____ Business Phone #_____
Do you text?_____May we text you? _____e-mail_____
Spouse's Name_____ Spouse's Employer_____

If Student, please answer 1-3
1-Grade Level_____ 2-School_____
3-Parent/Guardian's Name_____ Occupation_____

Whom may we thank for referring you to us?_____

Payment Options: (circle one) Cash Visa/Mastercard/Disc Care Credit Insurance
Insurance Company: (circle one) VSP EyeMed Medicaid Medicare Other

Credit Policy: Professional fees for services are due upon completion of the exam. At least one-half down payment is required before ordering any materials and the balance is due when the materials are received. Patient is responsible for paying balance not covered by insurance. Patient signature_____

CASE HISTORY
What is the main reason you are having your eyes examined?_____

_____
Date of last eye exam?_____Eye Doctor's name_____
Do you wear glasses?_____Contact lenses?_____How old are they?_____
When do you use them?_____Are they effective?_____
Do you engage in activities (job or recreation) where there are eye hazards?_____
Recreation/Hobbies_____Do you use a computer?_____
Are you interested in Glasses?_____Contact Lenses?_____LASIK Surg?_____

VISUAL HISTORY
Describe any eye or head injury, eye disease, surgery, or therapy you've had:_____

_____
Describe any family history of Glaucoma, Cataracts, Macular Degeneration, Retinal Disease_____

_____
Check all that apply to your eyes and vision **with** your current correction:

__blur at far
__blur at near
__sudden loss of vision
__floaters/spots
__flashing lights
__light sensitivity
__headaches
__double vision
__lazy eye/eye turn
__lid spasms
__pulling or strain
__pain behind the eyes
__redness
__burn, itch, or water
__other_____

HEALTH HISTORY

Please list all medications, drugs, vitamins you are currently taking_____

_____

Please check any of the following conditions that apply to you:

__Allergies_____ ___Smoker ___Pregnant

__Drug Allergies_____ ___Marijuana user ___Have given birth in the last 6 months

Are you under care for any disease or condition?_____

_____

Date of last complete physical exam?_____Physician_____

Describe any family history of High Blood Pressure, Diabetes, Heart Disease, or Cancer

_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

I, _____, have received a copy of Eisenhower Eyecare's Notice of Privacy Practices.

_____

Signature

_____

Date