eyecare focused on you

Date: ____________

Patient Name: ____________ (Last) ____________ (First) ____________ (M.I.) **Sex:** **M** **F**

Address: ____________ (Number & Street) ____________ (City & State) ____________ (Zip Code)

Phone: (   ) ____________ (Home) (   ) ____________ (Work) (   ) ____________ (Cell)

Email: ____________ **Preferred Method of Contact:** __ **Cell Phone** __ **Home Phone** __ **Work Phone**

SSN: **XXX - XX -** ________ **Age:** _____ **Date of birth** ___/___/___ (Mo. Day Yr.) **Spouse Name:** ____________

Your Employer: ____________ **Occupation:** ____________

Primary Language: ____________

Emergency Contact: ____________ (   ) ____________ (Phone) ____________ (Relationship to Patient)

Race: Check one ❑ **American Indian or Alaskan Native** ❑ **Asian** ❑ **Black or African American** ❑ **Native Hawaiian or Other Pacific Islander** ❑ **White** ❑ **Decline to Specify**

Ethnicity: Check one ❑ **Hispanic or Latino** ❑ **Not Hispanic or Latino** ❑ **Decline to Specify**

Do you have vision insurance? **VSP** ❑ **Superior** ❑ **Medicare** ❑ **EyeMed** ❑ **Cigna Vision** ❑ **Davis** ❑

Has any household member been a patient here? **Y / N** **Name(s)** ____________

Responsible Party/Policy Holder Information: ____________ (Last) ____________ (First) ____________ (M.I.)

DOB ____________ **SSN: XXX - XX -** ____________

Would you permit dilation of your eyes if requested Y N ________ (please initial)

Have you ever had an allergic reaction to any medication or anesthesia? Y N if so, which one(s) ____________

Services Requested today: _____ Vision Analysis/Eye Exam _____ Contact Lens Eval./Fitting

Urgent Care Services: _____ Eye Disease/Infection _____ Eye Injury _____ Foreign Body Injury

Other: ____________

Vision History

Do You Currently Have Glasses? Yes / No Age of Glasses? _______ Do You Wear Contacts? Yes / No Type ____________

Last Eye Exam? ____________ Name of Eye Doctor ____________

Review Of Systems / Medical History (circle all that apply)

Have you ever had or do you have any of the following:

Yes / No Allergies (seasonal hayfever)
Yes / No Cardiovascular Disease (hypertension, chest pain, etc.)
Yes / No Endocrine disease (diabetes, thyroid, etc.)
Yes / No Genitourinary (kidney, bladder, etc.)
Yes / No Immunologic (immune disease, AIDS, etc.)
Yes / No Neurologic (headaches, migraines, seizure, etc.)
Yes / No Respiratory (asthma, emphysema, etc.)
Yes / No Other Health Problems ____________

Yes / No Ear, Nose, Throat (hearing loss, sore throat)
Yes / No Constitutional (fever, fatigue, weight change, etc.)
Yes / No Gastrointestinal (ulcers, reflux, liver disease, etc.)
Yes / No Hematological/Lymphatic (anemia, leukemia, bleeding)
Yes / No Musculoskeletal (arthritis, neck, back, etc.)
Yes / No Psychiatric (depression, anxiety, etc.)
Yes / No Skin/Breast (rash, growths, cancer, etc.)

List Medications Currently Taking and Condition for Which Prescribed

____

Name of Family Physician ____________ Last Physical Exam ____________

Ocular Health History

Do You Have..

Yes / No__ Color Vision Defect
Yes / No__ Dry Eyes
Yes / No__ Corneal Disease
Yes / No__ Cataracts
Yes / No__ Glaucoma
Yes / No__ Retinal Detachment
Yes / No__ Macular Degeneration
Yes / No__ Eye Turning
Yes / No__ Double Vision

Other ____________

Ocular Medications

List All Eye Medications You Are Currently Using

____

____

____

____

Family Ocular History

Any family members with.. Relationship

Yes / No__ Color vision defect
Yes / No__ Dry Eyes
Yes / No__ Corneal Disease ____________
Yes / No__ Cataracts
Yes / No__ Glaucoma ____________
Yes / No__ Retinal Detachment
Yes / No__ Macular Degeneration ____________
Yes / No__ Eye Turn
Yes / No__ Double Vision ____________

Other ____________

Have You Had Eye Surgery or Eye Injuries? Explain and Give Dates ____________

Social History

Do You Smoke? Yes / No Frequency ____________
Do You Drink Alcohol Yes / No Frequency ____________
Do You Use Drugs? Yes / No Frequency ____________

Please continue and sign the back of this form

How Did You Learn About Our Office: ___Family ___Friend ___Coworker ___Physician Referral
___Insurance ___Phone Book ___Other: ____________________

General Office Policies and Acknowledgement of Receipt

Eyeglasses: By signing, I agree to the following: if there are any adaptation problems, and appointments needs to be made within 30 days from the date of dispense. I understand there is no refund or credit for any of downgrades made to my lenses due to lens style change or enhancement changes. I understand that I am responsible for the cost of new lenses after 30 days. I understand that Contact Lens Associates is not responsible for patient's own frames.

Contact lenses: By signing, I agree to the following: I am responsible for paying a fitting fee that does not include the cost of my contact lenses. Since I have agreed to start the fitting process, I am responsible for making any necessary appointments to finalize my prescription. I understand that the fitting process may require more than 3 visits. I am responsible for any new charges for any visits after 90 days. If I am unable to wear contact lenses after the fitting process, or if I choose to stop the fitting process, I understand my fitting fee is non refundable and no credit will be issued. Any contacts returned will be subject to a restocking fee.

I acknowledge that I have had the opportunity to review and understand the Contact Lens Associates, LLC Notice of Privacy Practices and General Office Policies.

Patient Name (please print): ______________________________________

Signature: ______________________________ Date: ________________