ALL EYES ON YOU, OPTOMETRY

WELCOME TO OUR OFFICE

Patient Information

Last _____
First_____MI _____
Street _____
City_____State _____
Zip Code _____ Sex F M
Date of Birth_____Age _____
Home Phone _____
Work Phone _____
Cell Phone _____
Email Address _____
How do you prefer to be contacted? (indicate preferences)
Home # __Work # __Cell # __Text # __Email # ___
Other/Emergency Contact _____
Employer (or School) _____
Occupation (or Grade) _____
Spouse (or Parent's Name) _____
Spouse (or Parent's Work) _____

What is the major purpose of this visit?

_____

Any problems with your current contact lenses or glasses?_____

_____

VERY IMPORTANT! NEW PATIENTS ONLY:
Who may we thank for referring you to our office?
Name of friend, relative or doctor:

_____

If not referred, how did you choose our office?
❑ Insurance List
❑ Saw Sign/Building
❑ Newspaper/Radio/TV
❑ Yellow Pages: Which directory? _____
❑ Web Page: Which Web Site? _____
❑ Other _____

The mission of All Eyes On You, Optometry is to contribute to a lifetime of healthy and efficient vision. We strive to provide each patient with incomparable vision care and thereby improve their quality of life. We will seek continuing education to remain at the forefront of our profession and will offer the latest eye care technology, professional services, and products. The visual needs and wellness of each patient will always be our first priority. We treat our patients as our family...and we will always treat you to popcorn upon request.

Insurance Information

Please note that insurance does NOT cover the Contact Lens Follow-Up Evaluation.

Vision Insurance_____
Subscriber Name_____
Subscriber SSN (**last 4 digits**)_____
Subscriber Birth Date_____

Primary Medical Insurance_____
Subscriber Name_____
Subscriber SSN (**last 4 digits**)_____
Subscriber Birth Date _____

Do you participate in a flex spending account?
❑ Yes ❑ No
How will you settle your account today?
❑ Cash ❑ Check ❑ Credit Card

Lifestyle Questions

Do you……(check box if your answer is yes)

❑..work at a computer?
❑..think you might benefit from thinner, lighter lenses?
❑..have interest in a "test drive" of the latest contact lens designs
❑..spend time outdoors? How much? Hrs/week
❑..have prescription sunwear?
❑..want information on Laser Vision Correction surgery?
❑..have interest in a non-surgical approach to vision correction?
❑..have more than 1 pair of current Rx eyewear?
❑..have children?
❑..have family members in need of eyecare?

Have you ever experienced, been diagnosed or treated for any of the following?

❑ Glaucoma
❑ Cataracts
❑ Macular Degeneration
❑ Retinal Detachment
❑ Flashes of light
❑ Floaters/Spots
❑ Crossed Eye/Eye Turn
❑ Lazy Eye
❑ Double Vision
❑ Loses place reading
❑ Poor reading ability
❑ Headaches
❑ Other eye disorders _____
❑ Eye Infections
❑ Eye Injury
❑ Corneal Abrasions
❑ Sunlight Sensitivity
❑ Trouble seeing at night
❑ Blurry Vision
❑ Itchiness
❑ Tearing
❑ Burning
❑ Occasional dryness
❑ Uncomfortable glasses
❑ Had Lasik

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_____
City_____
Date of Last Physical Check-up_____

CURRENT MEDICATIONS (Rx or Over the Counter)
(List name of medications including eye drops, vitamins, & birth control pills)_____

_____

_____

Allergies to medications? ❑ Yes ❑ No
If so, what medications? _____

_____

Use this space for any other health/medical information you would like to note:

Have you ever been diagnosed or treated for the following health problems?	**Yes**	**No**
Allergies	❑	❑
Rheumatoid Arthritis	❑	❑
High Blood Pressure	❑	❑
Cholesterol	❑	❑
Ears/Nose/Throat	❑	❑
Diabetes	❑	❑
Thyroid	❑	❑
Gastrointestinal	❑	❑
Genitourinary	❑	❑
Eczema/Rashes	❑	❑
Neurological	❑	❑
Psychiatric	❑	❑
Asthma	❑	❑
Cancer: Type _____	❑	❑

Welcome Back Please review and edit the front and back. Then sign and date to reflect it has been reviewed, including the previously signed acknowledgment of insurance/payment.

_____
Patient, Parent or Guardian Signature Date

_____
Patient, Parent or Guardian Signature Date

_____
Patient, Parent of Guardian Signature Date

Patient Eye History

Date of Last Eye Exam_____
By Whom?_____

Have you ever tried contact lenses? ❑ Yes ❑ No

Do you currently wear contact lenses? ❑ Yes ❑ No
What kind?_____
Solutions used_____

Are you satisfied with the vision and comfort of your contact lenses? ❑ Yes ❑ No

Would you prefer to dispose of your contact lenses daily?
❑ Yes ❑ No

Family Medical/Eye History (Check all that apply)

Is there a family medical history of any of the following:
❑ No ❑ Yes (Please check boxes below)

	Please Specify Relationship:
Glaucoma	❑_____
Cataracts	❑_____
Macular Degeneration	❑_____
High Blood Pressure	❑_____
Diabetes	❑_____
Corneal Problems	❑_____
Retinal Problems	❑_____
Lazy Eye	❑_____

Acknowledgement Regarding Insurance and Payment:
Please be advised: If you are using insurance coverage for today's visit, this is a contract between you and your insurance company...not All Eyes On You, Optometry.

Co-payments, deductibles, and all other non-covered or out-of-network fees for services and materials are due at the time services are rendered. I authorize payment of medical benefits directly to All Eyes On You, Optometry.

_____
Patient, Parent or Guardian Signature Date