Premier Eyecare & Eyewear
"Family Focused Lifetime Care"

WELCOME BACK TO OUR OFFICE

Today's Date _____

Patient Information

PLEASE COMPLETE IN BLACK INK ONLY

Last _____
First _____MI _____
Address _____
City _____
State_____ Zip Code _____
Home Phone _____
Cell Phone_____
Work Phone _____
Patient's SSN _____
DOB _____Age _____ Sex: M / F
Employer (or School) _____
Occupation (or Grade) _____
Spouse (or Parent's) Name _____
Spouse (or Parent's) Work _____
Email Address _____

Preferred method of contact:

___Text message,___Email, ___Phone call/message

Emergency Notification Name and Phone Number

_____

HIPPA Privacy: Premier Eyecare made available a copy of the HIPPA Privacy Notice. I have read and understand the notice**.** ***Only those whom I list*** in the space provided are authorized to discuss my medical care, billing or appointments with Premier Eyecare.

Name_____(#)_____-_____-_____

Name_____(#)_____-_____-_____

X _____

Signature of Patient or Representative

Please be advised if you are using insurance coverage for today's visit, this is a contract between you and your insurance company...not Premier Eyecare. By signing the insurance portion of this form, you are stating you understand this agreement.

If your insurance company has not reimbursed our office in full within 60 days, you are responsible for providing payment in full to Premier Eyecare.

Insurance Information

Please note that most insurance plans do NOT cover the contact lens evaluation.

Vision Insurance_____
Subscriber Name_____
Subscriber SSN_____
Subscriber Birth Date_____

Primary Medical Insurance_____
Subscriber Name_____
Subscriber SSN_____
Subscriber Birth Date_____

I authorize the release of any necessary medical information to process my insurance claim, and authorize payment of medical benefits.

Signature_____

_____

Lifestyle Questions

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

❑..work at a computer? If yes, please complete computer questionnaire.
❑..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?
❑..prefer not to wear your glasses at times?
❑..want information on Laser Vision Correction surgery?
❑..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?

❑ Blurry Vision
❑ Cataracts
❑ Crossed eye/Eye turn
❑ Eye Infections
❑ Flash of light
❑ Glaucoma
❑ Headaches
❑ Itchy eyes
❑ Macular Degeneration
❑ Retinal Detachment
❑ Tearing
❑ Uncomfortable glasses
❑ Other eye disorders_____
❑ Burning eyes
❑ Corneal Abrasions
❑ Double Vision
❑ Eye Injury
❑ Floaters/Spots
❑ Grittiness
❑ Iritis/Uveitis
❑ Lazy Eye
❑ Occasional dryness
❑ Sunlight Sensitivity
❑ Trouble seeing at night

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_____
Pharmacy & Location_____

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

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

Have you had any surgeries? ❑ Yes ❑ No

Do you use cigarettes/tobacco, alcohol, or other substances? ❑ Yes ❑ No

Have you ever been diagnosed or treated for the following health problems?

	Yes	No
Allergies	❑	❑
Arthritis	❑	❑
Blood/Lymph	❑	❑
Bronchitis	❑	❑
Cancer	❑	❑
Cholesterol	❑	❑
Diabetes	❑	❑
Digestive	❑	❑
Ears/Nose/Throat	❑	❑
Endocrine	❑	❑
Eczema/Rashes	❑	❑
Fatigue	❑	❑
Fevers	❑	❑
Genitourinary (genital/urinary)	❑	❑
Heart	❑	❑
High Blood Pressure	❑	❑
Integumentary (Skin)	❑	❑
Kidney	❑	❑
Muscle/Bone	❑	❑
Neurological	❑	❑
Psychological	❑	❑
Respiratory/Asthma	❑	❑
Sinus	❑	❑
Stroke	❑	❑
Throat Infections	❑	❑
Thyroid	❑	❑
Unusual weight losses/gains	❑	❑

Patient Eye History

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

If No, please explain_____
_____

Are you interested in being fit for contacts *today*?
❑ Yes ❑ No

Family Medical/Eye History (Check all that apply)

Is there a family medical history of any of the following:
(Parents, Grandparents, Siblings Only)

❑ **No** ❑ **Yes** (Please check boxes)

	RELATIONSHIP
Blindness	❑_____
Cataracts	❑_____
Corneal Problems	❑_____
Diabetes	❑_____
Glaucoma	❑_____
Heart Disease	❑_____
Lazy Eye	❑_____
Macular Degeneration	❑_____
Retinal Problems	❑_____

Please list any additional health information or concerns:

_____
_____
_____
_____

Doctor's initials_____ Date_____