Premier Eyecare & Eyewear
*"Family Focused Lifetime Care"*

# WELCOME 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

_____**(#)**_____-_____-_____

_____**(#)**_____-_____-_____

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

*If not referred, how did you choose our office?*

❑ Another Dr. ❑ Insurance List
❑ Saw Sign/Building ❑ Newspaper/Radio/TV
❑ Yellow Pages: Which directory? _____
❑ Web Page: Which Web Site? _____
❑ Other _____

**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 *Legal* Representative

## 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_____
Pharmacy &Location _____

**CURRENT MEDICATIONS (Rx or Over the Counter)**
(List name and dosage of medications 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 | ❑ | ❑ |

Other:_____
_____

## 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

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 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.

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. By signing the insurance portion of this form, you are stating you understand this agreement.

Doctor's Initials _____ Date_____