

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?

- | | |
|--|--|
| <input type="checkbox"/> Blurry Vision | <input type="checkbox"/> Burning eyes |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Corneal Abrasions |
| <input type="checkbox"/> Crossed eye/Eye turn | <input type="checkbox"/> Double Vision |
| <input type="checkbox"/> Eye Infections | <input type="checkbox"/> Eye Injury |
| <input type="checkbox"/> Flash of light | <input type="checkbox"/> Floaters/Spots |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Grittiness |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Iritis/Uveitis |
| <input type="checkbox"/> Itchy eyes | <input type="checkbox"/> Lazy Eye |
| <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Occasional dryness |
| <input type="checkbox"/> Retinal Detachment | <input type="checkbox"/> Sunlight Sensitivity |
| <input type="checkbox"/> Tearing | <input type="checkbox"/> Trouble seeing at night |
| <input type="checkbox"/> Uncomfortable glasses | |
| <input type="checkbox"/> Other eye disorders _____ | |

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	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Blood/Lymph	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Digestive	<input type="checkbox"/>	<input type="checkbox"/>
Ears/Nose/Throat	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine	<input type="checkbox"/>	<input type="checkbox"/>
Eczema/Rashes	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Fevers	<input type="checkbox"/>	<input type="checkbox"/>
Genitourinary (genital/urinary)	<input type="checkbox"/>	<input type="checkbox"/>
Heart	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Integumentary (Skin)	<input type="checkbox"/>	<input type="checkbox"/>
Kidney	<input type="checkbox"/>	<input type="checkbox"/>
Muscle/Bone	<input type="checkbox"/>	<input type="checkbox"/>
Neurological	<input type="checkbox"/>	<input type="checkbox"/>
Psychological	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory/Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Sinus	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Throat Infections	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Unusual weight losses/gains	<input type="checkbox"/>	<input type="checkbox"/>
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 _____