PATIENT INTAKE & HEALTH HISTORY

Patient Legal Name:	DOB:	Date:

Your minimum exam copayment today could be: Routine $_____ Medical $_____ Contact Fit $_____ (if applicable)

Final charges will be determined once your exam is completed.

Please mark your method of payment: Cash: _____ Check: _____ Debit/Credit: _____

PATIENT INFORMATION

Preferred Name	Gender	Age
Home Phone #	Home Address	
Cell Phone #		
Email Address	Employer	
SSN (if ins. requires)	Occupation	

RESPONSIBLE PARTY (if patient is a minor)

Parent/Guardian Full Name	Relationship to Patient
Date of Birth	Primary Phone #
Address	Email Address

VISION INSURANCE	MEDICAL INSURANCE
Insurance Carrier	Insurance Carrier
Policy Number	Policy Number
Group Number	Group Number
Secondary (if applicable)	Secondary (if applicable)

POLICY HOLDER INFORMATION (if different from patient)

Name (as shown on card)	Address
SSN (if ins. requires)	
Date of Birth	Primary Phone #

PRIMARY CARE INFORMATION

Physician Name	Phone #

☐ **By checking this box I agree to have my records or diagnosis information shared with my physician.**

PHARMACY INFORMATION

Pharmacy Name	City & Zip Code

HIPAA PRIVACY NOTICE

The HIPAA Policy was available to read during my office visit. _____ (patient initials)

We do not share your personal health information (PHI) with anyone without your authorization. In case of emergency, please provide information for one individual with whom we may share your medical records.

Authorized Individual _____ Phone Number _____

STATEMENT OF FINANCIAL RESPONSIBILITY

In order for my eyecare provider to service my account, or to collect any amounts I may owe, I agree that I may be contacted at any number or address I have provided above or during a previous encounter. I understand that my eye exam and any optional contact lens fitting copayments are due today, and glasses or contact lenses may not be dispensed if those copayments are unpaid. I also understand that fees for services are non-refundable and non-negotiable, and any contact lens prescriptions given are valid for one year per federal law. I furthermore agree to pay any collection expenses incurred to collect any amount I may owe due to non-payment. I understand that I am solely responsible for the cost of all non-covered items, as outlined in detail on my receipt which includes: the specific date of service, description of each procedure/service, and the amount I am responsible for paying out-of-pocket; I certify that I have been informed of all items and cost. I authorize the release of my information for my eyecare provider to file all insurance claims if we are a participating provider for your plan. However, there is no guarantee of benefit information and/or coverage and if my insurance denies payment for any claims submitted, I will be responsible for full payment and can contact my insurance company directly should there be a dispute. My eyecare provider can also supply me with an itemized statement which I may submit to my insurance carrier, should I need to submit for reimbursement. I understand that any follow-up appointments related to a contact lens evaluation are included for three months after the initial fitting, and should there be any follow-up appointments required after the three months have past, I am responsible to pay the professional service fee. Additionally, I know that any optional testing that I have verbally agreed to pay for, is my responsibility to do as such on the date of service. Should I receive a medical examination, I understand that my major medical insurance will be billed and I will be responsible for any deductibles, coinsurance or copayments that may be due.

☐ **I have read and understand the Statement of Financial Responsibility.**

Signature of Patient (or Parent/Guardian) _____ Date _____

Patient Name: DOB: Date:

PATIENT MEDICAL INFORMATION

Many medical conditions and medications affect the eyes. Please help the doctor by filling out your medical history as completely as possible.
Please check all of the conditions that apply to you:

Respiratory Issues	☐ Yes	☐ No	**Hematologic Conditions**	☐ Yes	☐ No	**Ear/Nose/Throat Problems**	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Sickle Cell	☐ Yes	☐ No	Sinus Problems	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No	Dental Problems	☐ Yes	☐ No
Skin Conditions	☐ Yes	☐ No	**Allergy/Immunology**	☐ Yes	☐ No	**Neurological Disorder**	☐ Yes	☐ No
Eczema	☐ Yes	☐ No	Hay Fever	☐ Yes	☐ No	Migraine Headaches	☐ Yes	☐ No
Rosacea	☐ Yes	☐ No	Sjogren's Syndrome	☐ Yes	☐ No	Multiple Headaches	☐ Yes	☐ No
Endocrine Disorder	☐ Yes	☐ No	Rheumatoid Arthritis	☐ Yes	☐ No	Multiple Sclerosis	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Lupus	☐ Yes	☐ No	Myasthenia Gravis	☐ Yes	☐ No
Thyroid Disorder	☐ Yes	☐ No	**Fever/Fatigue/Weight Loss**	☐ Yes	☐ No	Head Injury	☐ Yes	☐ No
Gastrointestinal Issues	☐ Yes	☐ No	**Musculoskeletal Conditions**	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Heartburn	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No	**Kidney/Bladder Problems**	☐ Yes	☐ No
Cardiovascular Conditions	☐ Yes	☐ No	**Psychiatric Disorder**	☐ Yes	☐ No	**Sexually Transmitted Diseases**	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No	Anxiety	☐ Yes	☐ No	**Cancer**	☐ Yes	☐ No
Heart Failure	☐ Yes	☐ No	Depression	☐ Yes	☐ No	**Surgical Operations**	☐ Yes	☐ No

Have you previously had any eye injuries, eye surgeries or eye diseases? ☐ Yes ☐ No If yes, please describe:

Have you experienced any floaters, flashes of light, burning, itching, redness, dryness, double vision, unusual blurry vision, frequent styes/chalazions, or excessive tearing/watering? ☐ Yes ☐ No If yes, please describe:

Do you have light sensitivity or issues with glare while outdoors or driving? ☐ Yes ☐ No ☐ Sometimes
Do you have issues with glare or have eye fatigue while on a computer? ☐ Yes ☐ No ☐ Sometimes

Are you currently being treated for any other medical conditions? ☐ Yes ☐ No If yes, please describe:

Please list any medications you are currently taking *(Including hormones, vitamins, birth control, aspirin, other anti-inflammatory, eye drops, etc.)* : ☐ None

Date of last general health exam: _____ Date of last eye exam: _____ Previous eye care provider: _____

Are you currently pregnant or nursing? ☐ Yes ☐ No
Do you smoke or use tobacco? ☐ Yes ☐ No ___Less than 1 Pack a Day ___1-2 Packs a Day ___2 Packs a Day
Do you drink alcohol? ☐ Yes ☐ No ___Social ___1-2 Drinks Daily ___Above Average Use ___Dependence
Are you allergic to any medications? ☐ Yes ☐ No If yes, please list: _____

CONTACT LENS INFORMATION

Do you currently wear contact lenses? ☐ Yes ☐ No If yes, please list the brand: _____

How many hours a day do you wear contacts? _____ How often do you throw away your lenses? _____

Do your eyes feel dry while wearing contacts? ☐ Yes ☐ No What do you use to clean your lenses?_____

FAMILY HISTORY

Has anyone in your family had any of the following illnesses?

Blindness*	☐ Yes	☐ No	Relationship: _____
Cancer*	☐ Yes	☐ No	Relationship: _____
Cataract	☐ Yes	☐ No	Relationship: _____
Color Blindness*	☐ Yes	☐ No	Relationship: _____
Diabetes*	☐ Yes	☐ No	Relationship: _____
Glaucoma*	☐ Yes	☐ No	Relationship: _____
Heart Disease	☐ Yes	☐ No	Relationship: _____
High Blood Pressure*	☐ Yes	☐ No	Relationship: _____
Lazy Eye*	☐ Yes	☐ No	Relationship: _____
Macular Degeneration*	☐ Yes	☐ No	Relationship: _____
Respiratory Disease	☐ Yes	☐ No	Relationship: _____
Retinal Detachment*	☐ Yes	☐ No	Relationship: _____

**Additional testing may be covered through your medical insurance.*

For Office Use Only

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