

Welcome to our office. In order to serve you better, we ask you to fill out this information sheet. Please print and complete all entries.

<b>Patient</b> (Last-First-Middle) _____	Home Phone _____
Address _____	Cell Phone _____
City/St _____ Zip _____	Drivers License No. _____
Date of Birth _____ Age _____	Social Security No. _____
Today's Date _____	Marital Status _____

Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Hobbies \_\_\_\_\_

Nearest relative not living with you \_\_\_\_\_ Relationship \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Please list other family members and ages \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_ Phone \_\_\_\_\_

What are your main concerns about this visit? \_\_\_\_\_

**Legally responsible person** (if patient a minor) \_\_\_\_\_ Home phone \_\_\_\_\_

Address \_\_\_\_\_ City/St \_\_\_\_\_ Zip \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Work Phone \_\_\_\_\_

Drivers License No. \_\_\_\_\_ Social Security No. \_\_\_\_\_ Marital Status \_\_\_\_\_

**Spouse:** [ ] of patient [ ] of Legally responsible person \_\_\_\_\_ Home phone \_\_\_\_\_

Address \_\_\_\_\_ City/St \_\_\_\_\_ Zip \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Work Phone \_\_\_\_\_

Drivers License No. \_\_\_\_\_ Social Security No. \_\_\_\_\_

METHOD OF PAYMENT TODAY WILL BE: [ ] Cash [ ] Check [ ] VISA/MasterCard/Discover

Vision Insurance \_\_\_\_\_ Group No. and Membership No. \_\_\_\_\_ Name of Insured \_\_\_\_\_

Major Medical Insurance Co. \_\_\_\_\_ Group No./Membership No. \_\_\_\_\_

**Patient Eye History:** (Please check all that apply) When was your last eye exam? \_\_\_\_\_

<input type="checkbox"/> Blurred distance vision	<input type="checkbox"/> Headaches	<input type="checkbox"/> Eye infections	<input type="checkbox"/> Loss of vision
<input type="checkbox"/> Blurred near vision	<input type="checkbox"/> Hay fever or allergies	<input type="checkbox"/> Styes	<input type="checkbox"/> Light flashes or floaters
<input type="checkbox"/> Poor night vision	<input type="checkbox"/> Dryness	<input type="checkbox"/> Cataracts	<input type="checkbox"/> Eye pain or soreness
<input type="checkbox"/> Tired eyes	<input type="checkbox"/> Redness	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Distorted vision or Halos
<input type="checkbox"/> Use a computer	<input type="checkbox"/> Sandy/ Gritty feeling	<input type="checkbox"/> Retinal Disease	<input type="checkbox"/> Double vision
<input type="checkbox"/> Glare or light sensitivity	<input type="checkbox"/> Watery or Itchy eyes	<input type="checkbox"/> Eye injury or surgery	<input type="checkbox"/> Lazy eye/ crossed eyes
<input type="checkbox"/> Other: _____			

**Patient Medical History:** (Please check all that apply)

<input type="checkbox"/> Headaches	<input type="checkbox"/> Asthma	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Constipation
<input type="checkbox"/> Seizures	<input type="checkbox"/> Chronic Bronchitis	<input type="checkbox"/> Heart Disease/ problems	<input type="checkbox"/> Syphilis/ Gonorrhea
<input type="checkbox"/> Fainting/dizziness	<input type="checkbox"/> Emphysema	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> HIV
<input type="checkbox"/> Allergies/ hayfever	<input type="checkbox"/> Chronic Obstructive	<input type="checkbox"/> Arteriosclerosis	<input type="checkbox"/> Arthritis/ joint pain
<input type="checkbox"/> Sinus trouble	<input type="checkbox"/> Pulmonary disease	<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Thyroid / Graves disease
<input type="checkbox"/> Dry throat or mouth	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Liver disease/ hepatitis
<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Bladder problems	<input type="checkbox"/> Skin disorders	

Explain: \_\_\_\_\_

Do you suffer from **any** disease not listed above? \_\_\_\_\_ If yes, what disease(s) \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Phone \_\_\_\_\_ Last Medical Exam \_\_\_\_\_

List **any** medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies) and give purpose: \_\_\_\_\_

Please list any medications you are allergic to: \_\_\_\_\_

List all major injuries, surgeries and/or hospitalizations you have had: \_\_\_\_\_

Are you pregnant and/or nursing? [ ] no [ ] yes

**Social History:** *This portion is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.*

\_\_\_\_ Yes, I would prefer to discuss my Social History information directly with my doctor. (please check)

Do you drive? [ ] yes [ ] no If yes, do you have visual difficulty when driving? [ ] yes [ ] no If yes, please describe: \_\_\_\_\_

<input type="checkbox"/> Smoke or use tobacco	<input type="checkbox"/> Drink Alcohol	<input type="checkbox"/> Illegal Drugs
<input type="checkbox"/> Exposed to excess sunlight	<input type="checkbox"/> Sexually transmitted diseases	

**Please turn this form over and complete side two**

**Family History**

Do you have any **blood** relatives (living or deceased) with a history of any of the following medical conditions:

	Relationship		Relationship		Relationship
Blindness	_____	Retinal Detachment/Disease	_____	High Blood Pressure	_____
Cataract	_____	Arthritis	_____	Kidney Disease	_____
Crossed Eyes	_____	Cancer	_____	Lupus	_____
Glaucoma	_____	Diabetes	_____	Thyroid Disease	_____
Macular degeneration	_____	Heart Disease	_____		
Other:	_____				

Would you like to discuss the latest LASER surgery that reduces the need for glasses or contacts? Yes \_\_\_ No \_\_\_

Are you interested in a non-surgical way to correct your vision? Yes \_\_\_ No \_\_\_

If you currently wear eyeglasses, does your spare pair have your correct prescription? Yes \_\_\_ No \_\_\_

If you currently wear prescription sunglasses, do they have UV (ultra-violet) protection? Yes \_\_\_ No \_\_\_ Not sure \_\_\_

If you currently wear eyeglasses, are there certain times when you would rather not? (For example-sports, business presentations, social occasions etc.) Yes \_\_\_ No \_\_\_

If you currently wear contact lenses, do your backup eyeglasses have your correct prescription? Yes \_\_\_ No \_\_\_

Have you **ever** worn contact lenses? Yes \_\_\_ No \_\_\_

If yes, check all that apply, even if worn for only a short time:

soft \_\_\_ hard \_\_\_ gas permeable \_\_\_ daily wear \_\_\_ extended wear \_\_\_ disposable \_\_\_  
monovision \_\_\_ tinted \_\_\_ bifocal \_\_\_ planned replacement \_\_\_

Do you currently wear contact lenses? Yes \_\_\_ No \_\_\_

If yes; soft \_\_\_ hard \_\_\_ gas permeable \_\_\_ daily wear \_\_\_ extended wear \_\_\_ disposable \_\_\_  
monovision \_\_\_ tinted \_\_\_ bifocal \_\_\_ planned replacement \_\_\_

Would you like to be fit or refit with contact lenses today? Yes \_\_\_ No \_\_\_

If yes, which of the following would you like to be fit with? Check all that apply. {Note: not all lenses are suitable for all patients. We will discuss what's available for your particular prescription, fitting parameters and lifestyle after the completion of your examination.}

soft \_\_\_ gas permeable \_\_\_ daily wear \_\_\_ extended wear \_\_\_ weekly disposable \_\_\_ daily disposable \_\_\_ bifocal \_\_\_  
monovision \_\_\_ planned replacement \_\_\_ tinted \_\_\_

Answer questions 1-8 **only if you currently wear contact lenses. If you do not currently wear contact lenses, skip to last section.**

- How old are your lenses?
- If you are NOT currently wearing disposable lenses, how often do you usually replace your lenses \_\_\_\_\_
- How many years have you worn lenses?
- What disinfection system do you use? Bausch & Lomb Renu \_\_\_ Alcon Optifree \_\_\_ Ciba AO Sept \_\_\_ Not sure of brand \_\_\_  
Other: (please list) \_\_\_\_\_
- What is your typical wearing schedule? \_\_\_ hrs/day, \_\_\_ days/week
- If you wear disposable lenses, what is your usual wearing schedule? dispose of daily \_\_\_ dispose of weekly \_\_\_
- Are you having **any** problems with your lenses? Yes \_\_\_ No \_\_\_
- Would you like to enhance or change your eye color with lenses? Yes \_\_\_ No \_\_\_

Payment is expected in full when services are rendered. **We do not bill. Eyeglasses and contact lenses must be paid for in full at the time of ordering.** Thank you for completing this form. Please return it to the front desk and we will be with you shortly.

I am responsible for any fees not paid by my insurance company. Any accounts with balances over thirty days will be charged interest at 1 1/2% per month (18% per annum) on the unpaid balance with a minimum charge of \$1.50 per month. I agree to pay court costs and reasonable attorney's fees if a delinquent balance is placed with a collection agency or attorney for collection or suit. I certify the above information is true and correct to the best of my knowledge.

Signature \_\_\_\_\_ Date \_\_\_\_\_  
If not patient, relationship to patient \_\_\_\_\_

Dr. Neil R. Nebeker