EYECHECK OPTOMETRY

Patient's Name_____ Date of Birth_____ Age_____ SS#_____

Address_____ City_____ Zip_____

Home Phone_____ Work #_____ Cell #_____

Email_____ Occupation_____ Employer_____

Marital Status: [ ] Married [ ] Single [ ] Separated [ ] Divorced [ ] Widow [ ] Other _____

Emergency Contact Name: _____ Relationship to Patient_____ Phone: _____

Who is responsible for this account? _____ Relationship to Patient_____

Primary Insurance Co: _____ ID# / SS#_____ Member Date of Birth_____

Secondary Insurance Co: _____ ID# / SS#_____ Relationship to Patient_____

Medical Insurance _____ ID# / SS#_____ Relationship to Patient_____

Please present all insurance cards to the receptionist / front desk.

Primary Care Doctor _____ Doctor's phone #_____

Reason for Today's Visit? _____

How did you hear about our practice?

[ ] former patient [ ] family comes hear [ ] referred by another patient _____

[ ] phone book [ ] insurance company [ ] referred by doctor (name)

[ ] location [ ] newspaper [ ] website (VSP.com) [ ] Walk In

Do you currently wear Glasses? [ ] Yes [ ] No [ ] Reading only [ ] Distance only

Have you ever worn Contact Lenses before? [ ] Yes [ ] No Type? _____

Do you wear Contact Lenses during sleep? [ ] Yes [ ] No

Are you interested in any of the following? [ ] Contact Lens wear [ ] Lasik surgery

Do you use a computer? [ ] Yes [ ] No Hobbies: _____

Smoking Status? [ ] Current [ ] Former [ ] Never Do you drink Alcohol? [ ] Yes [ ] No [ ] Special Occasions only

Eye History (Please check all boxes that apply to you)

[ ] Sandy, Gritty or Foreign Body Sensation

[ ] Burning/Stinging/Itching

[ ] Flashes / Floaters [ ] Blurry Vision

[ ] Eye Surgery / Eye Injury

[ ] Glaucoma [ ] Other _____

Do your family/relatives have any of the following?

[ ] Glaucoma [ ] Diabetes

[ ] Macular Degeneration [ ] Heart Disease

[ ] Blindness [ ] Tuberculosis

[ ] Lazy Eye [ ] High Blood Pressure

[ ] Other _____

Health History (Please check all boxes and conditions that apply to You)

[ ] High Blood Pressure

[ ] Diabetes or Thyroid Condition

[ ] Heart Disease

[ ] High Cholesterol or Anemia

[ ] Allergies, Lupus, Sjogren 's Syndrome

[ ] Asthma or Emphysema [ ] Other _____

[ ] Arthritis [ ] Skin

[ ] Neurological (Multiple Sclerosis, etc.)

[ ] Gastrointestinal (Ulcer, etc.)

[ ] Genital, Kidney, or Bladder

[ ] Sinus Trouble, Ear Infection, or Chronic Cough

[ ] Other _____

Current Medications: _____

_____

Allergies to Medications: _____

OFFICE POLICY

Services & Materials payment (including co-payments) is expected at the time services are rendered unless prior arrangements have been made.

Authorization

I certify that I have read and answered the above questions to the best of my knowledge. I authorize the eye doctor to release any information of treatment rendered to me or my child during the period of such eyecare to third party payers and/or health practitioners. I authorize my insurance company to pay directly to the eye doctor, benefits payable to me. I agree to be responsible for payment of all services rendered on my behalf or my dependents and /or payments for services rendered not covered by my insurance company.

Signature_____ Date_____

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