2nd Ins. Pays Refraction
☐ Yes ☐ No

Primary Eye Care
☐ **Yes** ☐ **No**

Appointment Time: _____
Appointment Date: _____
Provider:

Patient Id#:

M-cal Eligibility Status
☐ Green Light
☐ Yellow Light
☐ Red Light

Last Exam:

Patient Balance: _____

Above is for office Use only **Vsp Authorization #** _____ ☐ **Double Coverage** **Above is for office Use only**

☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms. ☐ Male ☐ Female

First Name | MI | Last Name | Preferred Name

Street Address | City | State | Zip

Social Security Number | Date of Birth | Home Phone - Include Area Code | Day Phone

Contact Phone - Area Code | Day/Cell Phone - Area Code | Work Phone - Include Area Code **Ext:**

Patients Spouse/Partner/Other

Patients Parents/Guardians
(Only If Patient Is Under 18.)

Email Address | Emergency Contact | Emergency Phone

PRIMARY INSURANCE INFORMATION

Name and Address of Primary Insurance Company | City | State | Zip

M ☐ F ☐ Insured's First Name | MI | Insured's Last Name

Insured's Identification Number | Group Number | Insured's Date of Birth

Patient Relationship to Insured
☐ Self ☐ Spouse ☐ Child ☐ Other

Patient Status
☐ Single ☐ Married ☐ Other
☐ Full Time Student ☐ Part Time Student ☐ Employed

SECONDARY INSURANCE INFORMATION

Name and Address of Secondary Insurance Company | City | State | Zip

M ☐ F ☐ Insured's First Name | MI | Insured's Last Name

Insured's Identification Number | Group Number | Insured's Date of Birth

Patient Relationship to Insured
☐ Self ☐ Spouse ☐ Child ☐ Other

BELOW IS OFFICE USE ONLY

Optomap: YES NO (this is an extra charge due at time of service.) **B/P:** / **P:**

Optomap last year: ☐ **YES** _____ ☐ **NO** **OptomapPlus:** _____

V/F Lens(es) used:
OD: **OS:**

30-2 / 24-2 RX
OD: **OS:**

Notes From Dr:

Wearing Contacts: ☐ **YES**

Name

Race

PATIENT HISTORY AND INFORMATION

☐ American Indian Or Alaska Native ☐ Other Race ☐ Refuse To Specify
☐ Asian ☐ White ☐ Not Disclosed
☐ Black Or African American ☐ Native American
☐ Native Hawaiian Or Other Pacific Islander ☐ Caucasian

Other Race

Ethnicity ○ Hispanic Or Latino ○ Not Hispanic Or Latino ○ Unknown

Preferred Language ○ English ○ Spanish ○ French ○ Italian ○ Russian ○ Portuguese

Height ft [ ] in [ ] cm/m [ ] ○ ft in ○ cm ○ m **Weight** [ ] ○ lbs ○ kg

SOCIAL HISTORY

Current Occupation : _____ Years _____ Employer _____

PRIMARY CARE PHYSICIAN

_____

Primary Care Physician and Clinic Name

_____

Address of Primary Care Physician City State Zip Phone

HEALTH HISTORY

What is the main reason for today's exam ? _____

When was your last health exam ? _____

Past Illnesses or Injuries: _____ _____

Past Surgeries: _____ _____

Current Medications
And Dosage for each: _____ _____

_____ _____

Current Eye Drops: _____ _____

_____ _____

Medicines that cause reactions or sensitivities: _____

Specific Allergies: _____

EYE HISTORY

Glaucoma	○ Yes ○ No	Dryness	○ Yes ○ No	Strabismus (Crossed Eyes)	○ Yes ○ No
Cataract	○ Yes ○ No	Excess Tearing/Watering	○ Yes ○ No	Blurred Vision Distance	○ Yes ○ No
Macular Degeneration	○ Yes ○ No	Eye Pain or Soreness	○ Yes ○ No	Blurred Vision Near	○ Yes ○ No
Retinal Detachment	○ Yes ○ No	Foreign Body Sensation	○ Yes ○ No	Distorted Vision (halos)	○ Yes ○ No
Color Blindness	○ Yes ○ No	Infection of Eye or Lid	○ Yes ○ No	Double Vision	○ Yes ○ No
Headaches	○ Yes ○ No	Itching	○ Yes ○ No	Floaters or Spots	○ Yes ○ No
Glare/Light Sensitivity	○ Yes ○ No	Mucous Discharge	○ Yes ○ No	Fluctuating Vision	○ Yes ○ No
Tired Eyes	○ Yes ○ No	Drooping Eyelid	○ Yes ○ No	Loss of Vision	○ Yes ○ No
Amblyopia (Lazy Eye)	○ Yes ○ No	Redness	○ Yes ○ No	Loss of Side Vision	○ Yes ○ No
Burning	○ Yes ○ No	Sandy or Gritty Feeling	○ Yes ○ No		

GENERAL HEALTH CONDITION

Fever	○ Yes ○ No	Respiratory (Asthma)	○ Yes ○ No	Anxiety or Depression	○ Yes ○ No
Weight Loss	○ Yes ○ No	Gastrointestinal	○ Yes ○ No	Thyroid, Diabetes	○ Yes ○ No
Other Symptoms	○ Yes ○ No	Kidney	○ Yes ○ No	Blood/Lymph	○ Yes ○ No
Ears,Nose,Throat	○ Yes ○ No	Muscles,Bones,Joints	○ Yes ○ No	Allergic	○ Yes ○ No
Cardiovascular (high	○ Yes ○ No	Skin	○ Yes ○ No	Are you?	☐ Pregnant ☐ Nursing
blood pressure etc.)		Neurological (Multiple Sclerosis)	○ Yes ○ No		

Name

MEDICAL HISTORY QUESTIONAIRE

FAMILY HISTORY

		Relationship
Amblyopia (Lazy Eye)	O Yes O No	
Blindness	O Yes O No	
Cataract(s)	O Yes O No	
Color Blindness	O Yes O No	
Glaucoma	O Yes O No	
Macular Degeneration	O Yes O No	
High Blood Pressure	O Yes O No	
Kidney Disease	O Yes O No	
Lupus	O Yes O No	
Stroke	O Yes O No	
Thyroid Disease	O Yes O No	
Others	O Yes O No	

		Relationship
Retinal Detachment	O Yes O No	
Strabismus (Eye Turn)	O Yes O No	
Arthritis	O Yes O No	
Cancer	O Yes O No	
Diabetes	O Yes O No	
Heart Disease	O Yes O No	

SPECTACLE HISTORY

Do you currently wear glasses ? O Yes O No Since _____

Type of glasses ☐ FullTime ☐ PartTime ☐ Distance ☐ Close

Glasses Owned ☐ SingleVision ☐ Bifocals ☐ Trifocals ☐ Backup ☐ Safety ☐ Sports ☐ Progressive

Have you had trouble in the past with glasses? O Yes O No _____

Do you wear sunglasses? O Yes O No Are your sunglasses your current prescription ? O Yes O No

CONTACT LENS HISTORY

If not a contact lens wearer, are you interested in trying contact lenses at this time ? O Yes O No

Have you ever tried to wear contact lenses? O Yes O No Reason for stopping? _____

Do you currently wear contact lenses? O Yes O No Since _____

Type and brand of contact lenses _____ Today's wearing time ? _____

How many hours/day ? _____ How many days/week ? _____

SOCIAL HISTORY

Do you use nutritional supplements (vitamins etc.)? O Yes O No

Do you engage in regular exercise? O Yes O No

Do you drink alcohol ? If yes, how much/often : O No O Occasional O 1 Per Day O 2-3/day O 4+/day

Do you smoke ? If yes, how much/often : O No O Occasional O 1/2 pack/day O 1 pack/day O 1+ pack

Past Smoker: If yes, when did you stop: O Yes O No _____

Smoking Status (Current, Former, Never) _____

Method of Tobacco Intake : O Smoking O Chewing

Do you use Illegal Drugs : O Yes O No

Please Read:

In order to control the cost of billing, we ask that the patient's portion is paid at the time services are rendered unless other arrangements are made in advance. We would rather control billing costs than be forced to raise our fees. All professional services and material are charged to the patient.The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Accounts 90 days old are subject to collection fees. There will be a service charge on all returned checks.

Payment from my insurance is to be paid directly to . I understand that will be billed as my primary insurance. I understand that billing any secondary insurance is my responsibility. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed.

_____ _____

Signature Date

If patient is under 18 years of age, parent/guardian(s) signature is required.