clear vision family eyeca

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Welcome!

Today's Date _____

Patient Information

Last _____
First _____ MI _____
Street _____
City _____ State _____
Zip Code _____
Home Phone _____
Cell Phone _____
Date of Birth _____ Age _____
Sex M F
Patient's SSN _____
Employer (or School) _____
Occupation (or Grade) _____
Spouse (or Parent's Name) _____
Spouse (or Parent's Work) _____

Email Address _____

What brought you in today?

_____

Any problems with your current contact lenses or glasses? ❑ Yes (Will discuss with the doctor)
❑ No

How many pairs of current prescription glasses do you own?_____

Who may we thank for referring you to our office?

_____

If you were not referred, how did you hear about us?
❑ Insurance list
❑ Saw Sign or Building
❑ Newspaper/ Newsletter
❑ Yellow Pages: Which Directory?_____
❑ Web Page: Which Site?_____
❑ Other_____

Our Mission is to care for each person seen at Clear Vision Family Eyecare in such a respectful, memorable way that when the day is done you share your experience with another.

Insurance Information

Vision Insurance_____
Subscriber Name_____
Subscriber SSN_____
Subscriber Birth Date_____

Primary Medical Insurance_____
Subscriber Name_____
Subscriber SSN_____
Subscriber Birth Date_____

Do you participate in a flex spending account?
❑ Yes ❑ No
How will you settle your account today?
❑ Cash ❑ Check ❑ Credit Card

Lifestyle Questions

Do you……(check box if your answer is yes)
❑..work at a computer? If yes- how many hours/day?____
❑..think you might benefit from thinner, lighter lenses?
❑..spend time outdoors? How much? __Hrs/week
❑..have prescription sunwear?
❑..prefer not to wear your glasses at times?
❑..drive at night?
❑..want information on Laser Vision Correction surgery?
❑..have more than 1 pair of current Rx eyewear?
❑..feel your eyes are tired?
❑..have children?
❑..have family members in need of eyecare?

Have you ever experienced, been diagnosed or treated for any of the following?

❑ Blurry Vision
❑ Burning
❑ Cataracts
❑ Corneal Abrasions
❑ Crossed eye/Eye turn
❑ Double Vision
❑ Eye Infections
❑ Eye Injury
❑ Flash of light
❑ Floaters/Spots
❑ Glaucoma
❑ Grittiness
❑ Headaches
❑ Iritis/Uveitis
❑ Itchiness
❑ Lazy Eye
❑ Macular Degeneration
❑ Occasional dryness
❑ Retinal Detachment
❑ Sunlight Sensitivity
❑ Tearing
❑ Trouble seeing at night
❑ Uncomfortable glasses
❑ 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_____
Town_____
Date of Last Physical Check-up_____

CURRENT MEDICATIONS (Rx or Over the Counter)
(List name of medications including eye drops, vitamins, & birth control pills)_____
_____
_____

Allergies to medications? ❑ Yes ❑ No
If so, what medications?_____
_____

Are you currently pregnant or nursing? ❑ Yes ❑ No
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**
Chills/Fever	❑	❑
Fatigue	❑	❑
Sudden weight loss/gain	❑	❑
High Blood Pressure	❑	❑
High Cholesterol	❑	❑
Ear/Nose or Throat	❑	❑
Respiratory	❑	❑
Digestive	❑	❑
Genitourinary	❑	❑
Arthritis	❑	❑
Integumentary (Skin)	❑	❑
Eczema/Rashes	❑	❑
Neurological	❑	❑
Psychological	❑	❑
Endocrine	❑	❑
Blood disorder	❑	❑
Allergies	❑	❑
Kidney	❑	❑
Muscle/Bone	❑	❑
Cancer	❑	❑
Other	❑	❑

Please describe any "yes" below:
_____
_____

Patient Eye History

Last Eye Doctor:_____
When was last eye exam?_____

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

Would you prefer clear contact lenses or colored contact lenses? ❑ Clear ❑ Colored

If you wear bifocals, do the lines or head tilting bother you? ❑ Yes ❑ No

Family Medical/Eye History (Check all that apply)

Is there a family medical history of any of the following:
❑ No ❑ Yes (Please check boxes)

	Relationship
Glaucoma	❑_____
Cataracts	❑_____
Macular Degeneration	❑_____
Retinal Disease	❑_____
Blindness	❑_____
Eye Turn/Cross	❑_____
Lazy Eye	❑_____
Diabetes	❑_____
Cancer	❑_____
Heart Disease	❑_____
High Blood Pressure	❑_____
Other	❑

Please be advised if you are using insurance coverage for today's visit, this is a contract between you and your insurance company...not Clear Vision Family Eyecare.

If your insurance company has not reimbursed our office in full within 60 (or 90) days, you will be responsible to all charges and your insurance company will then pay you directly. (If by mistake your insurance company sends the payment check to us, we will of course sign over and forward the check directly to you.)

Signature_____

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Because There is so Much to See.