WELCOME TO OUR OFFICE

Patient Information

Today's Date ______________________________

Last ______________________________________
First ____________________ MI ______________
Street ____________________________________
City ______________ State _____ Zip ___________
Home Phone _______________________________
Cell Phone ________________________________
Work Phone _______________________________
Patient's SSN _____________________________
Date of Birth ___________________ Age ________
Sex M F
Email Address _____________________________
Employer (or School) ________________________
Occupation (or Grade) _______________________

Who is responsible for patient's expenses?
❑ Self (skip this section) ❑ Parent/Guardian
Last ______________________________________
First ____________________ MI ______________
SSN ______________________________________
Date of Birth _______________________________
Street ____________________________________
City ______________ State _____ Zip ___________
Home Phone _______________________________
Cell Phone ________________________________
Work Phone _______________________________
Employer _________________________________

What is the major purpose of this visit?

____

Any problems with your current contact lenses or glasses?

____

VERY IMPORTANT! NEW PATIENTS ONLY:

Who may we thank for referring you to our office?
Name of friend or relative ____________________
If not referred, how did you choose our office?
❑ Another Dr.________________________
❑ Insurance List
❑ Saw Sign/Building
❑ Newspaper/Radio/TV
❑ Yellow Pages: Which directory? _____________
❑ Web Page: Which Web Site? ________________
❑ Other ___________________________________

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? ❑..eyes tire easily on computer?
❑..think you might benefit from thinner, lighter lenses?
❑..have interest in a "test drive" of the latest contact lens designs
❑..spend time outdoors? Some A lot All day
❑..wear 100% UV, polarized sunglasses when outdoors?
❑..have prescription sunglasses?
❑..prefer not to wear your glasses at times?
❑..want information on Laser Vision Correction surgery?
❑..have more than 1 pair of current Rx eyewear?
❑..have children?
❑..have family members in need of eyecare?

Please list specific hobbies/activities you participate in:
❑ golf ❑ fishing ❑ tennis ❑ gardening ❑ running
❑ cycling ❑ hiking ❑ swimming ❑ walking
❑ water skiing ❑ snow skiing ❑ motorcycling
❑ other ________________________________

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

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

Please Continue On Other Side

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____
If needed, is it ok for us to send a report to your doctor concerning today's appointment? ❑ Yes ❑ No

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?________________________
____

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**
Allergies	❑	❑
Arthritis	❑	❑
Blood/Lymph	❑	❑
Bronchitis	❑	❑
Cancer	❑	❑
Cholesterol	❑	❑
Diabetes	❑	❑
Digestive	❑	❑
Ears/Nose/Throat	❑	❑
Endocrine	❑	❑
Eczema/Rashes	❑	❑
Fatigue	❑	❑
Fevers	❑	❑
Genitourinary	❑	❑
Heart failure	❑	❑
High Blood Pressure	❑	❑
HIV/AIDS	❑	❑
Integumentary (Skin)	❑	❑
Kidney	❑	❑
Muscle/Bone	❑	❑
Neurological	❑	❑
Psychological	❑	❑
Respiratory	❑	❑
Sinus	❑	❑
Throat Infections	❑	❑
Thyroid	❑	❑
Unusual weight losses/gains	❑	❑

Patient Eye History

Date of Last Eye Exam________________________
By Whom?________________________

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 (Mother's or Father's side)
Blindness	❑________________
Cataracts	❑________________
Corneal Problems	❑________________
Diabetes	❑________________
Glaucoma	❑________________
Heart Disease	❑________________
Lazy Eye	❑________________
Macular Degeneration	❑________________
Retinal Problems	❑

Please be advised if you are using insurance coverage for today's visit, this is a contract between you and your insurance company...not Modern Eyecare Center. If for some reason your insurance company does not pay, you will be responsible for incurred charges.

Signature ______________________ Date ____________

Modern Eyecare Center
& EYEWEAR BOUTIQUE