PLEASE PRINT

PATIENT INFORMATION

Date _____

Patient Name _____ Birthday _____ Age _____

Address _____ City _____ Zip _____

Phone Home _____ Work _____ Male _____ Female _____

Employer (School) _____ Occupation (Grade) _____

Payment Cash _____ Check _____ VISA/MC _____ Insurance _____ SSN _____

How did you hear about this office? (✓ one) ☐ Ad/Yellow Pages ☐ Walk-in ☐ Ins. Listing ☐ Referred by _____

Please Note: Payment is requested when services are provided. Unless your insurance policy includes specific vision benefits, routine eye examinations are generally not covered unless you have a medical eye condition.

EYE HEALTH HISTORY

Last Eye Doctor _____

Date of last visit _____

Date of last eye exam? _____

Do you wear contacts ☐ Yes ☐ No

Do you wear glasses? ☐ Yes ☐ No

☐ All the time ☐ Occasionally

☐ Reading ☐ Driving ☐ TV

Place a mark on "Yes" or "No" to indicate if you have had any of the following

Bloodshot Eyes	☐ Yes	☐ No	Floaters or Spots	☐ Yes	☐ No
Blurred Vision – Distance	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No
Blurred Vision – Near	☐ Yes	☐ No	Headaches	☐ Yes	☐ No
Burning Eyes	☐ Yes	☐ No	Itching Eyes	☐ Yes	☐ No
Cataracts	☐ Yes	☐ No	Light Sensitive	☐ Yes	☐ No
Color Vision, Poor	☐ Yes	☐ No	Loss of Vision	☐ Yes	☐ No
Crossed Eyes	☐ Yes	☐ No	Migraine Headaches	☐ Yes	☐ No
Discharge from Eyes	☐ Yes	☐ No	Night Vision, Poor	☐ Yes	☐ No
Dizzy Spells	☐ Yes	☐ No	Red Eyes	☐ Yes	☐ No

HEALTH HISTORY

Physician's Name _____ Date/of last visit _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following. Also place a line to indicate if a blood relative has had any of the following problems.

	Yourself	Family Members
AIDS/HIV	☐ Yes ☐ No	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	☐ Yes ☐ No
Artificial Heart Valve	☐ Yes ☐ No	☐ Yes ☐ No
Artificial Joints	☐ Yes ☐ No	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	☐ Yes ☐ No
Bleeding	☐ Yes ☐ No	☐ Yes ☐ No
Blindness	☐ Yes ☐ No	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	☐ Yes ☐ No
Drug Sensitivity	☐ Yes ☐ No	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	☐ Yes ☐ No
Epilepsy	☐ Yes ☐ No	☐ Yes ☐ No
Eye Surgery	☐ Yes ☐ No	☐ Yes ☐ No
Glaucoma	☐ Yes ☐ No	☐ Yes ☐ No
Hay Fever	☐ Yes ☐ No	☐ Yes ☐ No
Heart Condition	☐ Yes ☐ No	☐ Yes ☐ No
Hepatitis (Type _____)	☐ Yes ☐ No	☐ Yes ☐ No

	Yourself	Family Member
High Blood Pressure	☐ Yes ☐ No	☐ Yes ☐ No
Lazy Eye	☐ Yes ☐ No	☐ Yes ☐ No
Lupus	☐ Yes ☐ No	☐ Yes ☐ No
Migraine Headache	☐ Yes ☐ No	☐ Yes ☐ No
Pacemaker	☐ Yes ☐ No	☐ Yes ☐ No
Kidney Disease/Dialysis	☐ Yes ☐ No	☐ Yes ☐ No
Sarcoidosis	☐ Yes ☐ No	☐ Yes ☐ No
Sickle Cell/Trait	☐ Yes ☐ No	☐ Yes ☐ No
Retinal Disease	☐ Yes ☐ No	☐ Yes ☐ No
Shingles	☐ Yes ☐ No	☐ Yes ☐ No
Skin Conditions	☐ Yes ☐ No	☐ Yes ☐ No
Stroke	☐ Yes ☐ No	☐ Yes ☐ No
Thyroid Condition	☐ Yes ☐ No	☐ Yes ☐ No
Tuberculosis	☐ Yes ☐ No	☐ Yes ☐ No
Turned Eye	☐ Yes ☐ No	☐ Yes ☐ No
Other _____	☐ Yes ☐ No	☐ Yes ☐ No

Are you pregnant _____ Number of children _____

Tobacco use _____ Alcohol use _____

- OVER -

MEDICATIONS	ALLERGIES
List medications you are currently taking, including eye drops: _____ _____ _____ _____ Pharmacy Name_____ Phone_____	List your allergies to medications or other substances: _____ _____ _____ _____ _____ _____

PUPIL DILATION

Depending on the findings of your exam, the doctor may wish to use eyedrops to dilate your pupils. **Common side effects of the drops used in the dilating process are increased glare and reduction in near focusing ability. Distance vision is usually not significantly affected.** The process is painless and lasts from 3 to 5 hours. If you have any questions please ask the doctor.

____ I do give my permission for diagnostic drops to be instilled in my eyes.

____ I do not wish to have my eyes dilated at this time. I am aware of the benefits of the procedure in the early detection of eye disease, tumors, and other related disorders.

_____
Patient Signature

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance with _____ and assign **The Eyecare Studio** all insurance benefits otherwise payable to me for ser-vices rendered. I understand I am responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to submit information necessary to secure benefits. I authorize the use of this signature on all insurance submitted.

_____
Responsible Party Signature

_____ _____
Relationship Date

Comments _____