Day of Exam – Patient Information

Welcome to our office.
To better serve you today, please fill out **BOTH** sides of this
form so that we may give you the best vision care possible.

Today's Date _____

Last Name _____ First Name _____ Initial _____
Address _____
City _____ State _____ ZIP _____
Home Phone _____ Work Phone _____
Social Security No. _____ Date of Birth _____
Employer _____ Occupation _____
Date of Last Eye Exam _____In our office? No ___ Yes___
Sex: Male ____ Female ____
Marital Status: Single___ Married___ Widowed___ Divorced___
If Patient is a child: School Grade _____ Parent Name: _____

So. Durango ___ Sierra Vista ___
Civic Center ___
Centennial Hills ___

How did you hear of us: TV___ Radio___ Mail___ Yellow Pages ___, or you were referred to us by _____ so we may send them a thank you.
So we may send you important notices, may we have your:
E-Mail Address_____ Phone Text Number _____

Insurance Information

Is this visit payable by insurance? Yes ___ No ___
If Yes: Name of Insurance _____
Name of Insured Member _____
Where Employed _____
Social Security # of Member _____
Members birth date _____

AUTHORIZATION TO PAY BENEFITS: I hereby authorize my insurance company to pay all benefits for the services described to The Eyecare Center. I also understand that I am personally responsible for all charges incurred. A copy of this authorization shall be as valid as the original. I have read and understood the general office policies stated below.

Signature of Member _____ Date _____

General Office Policies

(1) A **non-refundable** deposit is required on all materials ordered. Materials will be held for 30 days after notification for pick-up before being returned to our suppliers, resulting in **LOSS** of deposit. (2) A $30 service charge on all returned checks. (3) No-line Progressive bifocals can be remade within 30 days of dispensing to a standard FT28 bifocal at no additional charge. (4) There are **NO** refunds. (5) Opened vials or boxes of contact lenses **cannot** be exchanged. Only contact lenses purchased in our office may be exchanged. (6) Our office Notice of Privacy Practices as mandated under HIPAA is posted in the reception area of each office. A copy is available at your request at the front desk of each office. (7) Patient records will be kept for a period of five (5) years from the last exam.

Signature of Patient _____ Date _____

COMPLETE NEXT SIDE

Personal Medical Information

What is your general health? Good ___ Fair ____ Poor ____ Height_____ Weight_____

Do you have any problems with any of the below? (**circle those that apply**)

Eyes	No__ Yes__	Arthritis	No__ Yes__
Gastrointestinal	No__ Yes__	Stroke	No__ Yes__
Ears/Nose/Throat	No__ Yes__	Sarcoidosis	No__ Yes__
Cardiovascular	No__ Yes__	Lymphoma	No__ Yes__
Respiratory	No__ Yes__	Leukemia	No__ Yes__
Nervous	No__ Yes__	Blood/Lymph	No__ Yes__
Mental	No__ Yes__		

Are You Diabetic? No__ Yes__ Type _____ How Long? _____yrs

Allergies? No__ Yes__ Allergic to what? _____

Do You Use Tobacco? No__ Yes__ Alcohol? No__Yes__ Other substances? No__Yes__

List ALL Medications you are taking: _____

_____

_____

_____

Family Medical History

DOES ANYONE IN YOUR FAMILY HAVE:

High Blood Pressure: Yes___ No___ Relation: _____

Diabetes: Yes___ No___ Relation: _____

Glaucoma: Yes___ No___ Relation: _____

Macular Degeneration Yes___ No___

Retinal Detachment Yes___ No___

Cataracts: Yes___ No___

Other Eye Condition(s): Yes___ No___ What kind?_____

Personal Eye Information

Have you had any eye operations? Yes___ No___ Type _____ Date _____

Have you had an eye injury? Yes___ No___ Kind _____

Do you have Glaucoma? Yes___ No___ Do you get headaches? Yes___ No___

Do you have Cataracts? Yes___ No___ Do you have dry eyes? Yes___ No___

Do your eyes: Burn__ Water__ Itch__ Ache__ Tire__

Do you have blurred vision? Yes___ No___ Far away? ___ Up close? ___

Other eye problems? What kind _____

Do you wear glasses? Yes___ No___

Do you wear contact lenses? Yes___ No___ What type _____

Are You Interested In Contact Lenses Today? Yes_____ No_____

Other Members of Your Family:

NAME	Relation	Age	Date of last eye exam