



WELCOME TO OUR OFFICE

Today's Date _____

Patient Information

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

What is the major purpose of this visit?

Are there 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 _____

***Our mission: To Provide a welcoming atmosphere for every patient and to surpass the patients expectations
By providing the highest quality of service through the latest innovations, education, and personalize Care!***

Insurance Information

Please note that insurance does NOT cover the Contact Lens Follow-Up Evaluation.

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, please complete computer questionnaire.
 ..think you might benefit from thinner, lighter lenses?
 ..have interest in a "test drive" of the latest contact lens designs
 ..spend time outdoors? How much? ___Hrs/week
 ..have prescription sunwear?
 ..prefer not to wear your glasses at times?
 ..want information on Laser Vision Correction surgery?
 ..have interest in a non-surgical approach to vision correction?
 ..have more than 1 pair of current Rx eyewear?
 ..have children?
 ..have family members in need of eyecare?

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

<input type="checkbox"/> Blurry Vision	<input type="checkbox"/> Burning
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Corneal Abrasions
<input type="checkbox"/> Crossed eye/Eye turn	<input type="checkbox"/> Double Vision
<input type="checkbox"/> Eye Infections	<input type="checkbox"/> Eye Injury
<input type="checkbox"/> Flash of light	<input type="checkbox"/> Floaters/Spots
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Grittiness
<input type="checkbox"/> Headaches	<input type="checkbox"/> Iritis/Uveitis
<input type="checkbox"/> Itchiness	<input type="checkbox"/> Lazy Eye
<input type="checkbox"/> Macular Degeneration	<input type="checkbox"/> Occasional dryness
<input type="checkbox"/> Retinal Detachment	<input type="checkbox"/> Sunlight Sensitivity
<input type="checkbox"/> Tearing	<input type="checkbox"/> Trouble seeing at night
<input type="checkbox"/> Uncomfortable glasses	
<input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If so, what medications? _____		

Have you had any surgeries? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Do you use cigarettes/tobacco, alcohol, or other substances? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Have you ever been diagnosed or treated for the following health problems?		
	Yes	No
Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Blood/Lymph	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Digestive	<input type="checkbox"/>	<input type="checkbox"/>
Ears/Nose/Throat	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine	<input type="checkbox"/>	<input type="checkbox"/>
Eczema/Rashes	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Fevers	<input type="checkbox"/>	<input type="checkbox"/>
Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Integumentary (Skin)	<input type="checkbox"/>	<input type="checkbox"/>
Kidney	<input type="checkbox"/>	<input type="checkbox"/>
Muscle/Bone	<input type="checkbox"/>	<input type="checkbox"/>
Neurological	<input type="checkbox"/>	<input type="checkbox"/>
Psychological	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>
Sinus	<input type="checkbox"/>	<input type="checkbox"/>
Throat Infections	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Unusual weight losses/gains	<input type="checkbox"/>	<input type="checkbox"/>

Patient Eye History
Date of Last Eye Exam _____
By Whom? _____
Have you ever tried contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you currently wear contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No
What kind? _____
Solutions used _____
Are you satisfied with the vision and comfort of your contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No
Would you prefer clear contact lenses or colored contact lenses? <input type="checkbox"/> Clear <input type="checkbox"/> Colored
If you wear bifocals, do the lines or head tilting bother you? <input type="checkbox"/> Yes <input type="checkbox"/> No

Family Medical/Eye History (Check all that apply)
Is there a family medical history of any of the following: <input type="checkbox"/> No <input type="checkbox"/> Yes (Please check boxes)
Relationship (Mother's or Father's side)
Blindness <input type="checkbox"/> _____
Cataracts <input type="checkbox"/> _____
Corneal Problems <input type="checkbox"/> _____
Diabetes <input type="checkbox"/> _____
Glaucoma <input type="checkbox"/> _____
Heart Disease <input type="checkbox"/> _____
Lazy Eye <input type="checkbox"/> _____
Macular Degeneration <input type="checkbox"/> _____
Retinal Problems <input type="checkbox"/> _____

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

If your insurance company has not reimbursed our office in full within 60 days, your credit card will be utilized 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.)

Please enter your credit card number and expiration date. Please be advised that Acuity Vision Care is not responsible for any over draft fees.

CC#: _____

Expiration Date: _____

Signature _____

