Eye & Vision

The information is confidential and only used for office purposes such as notices, recalls, confirming appointments and passwords to order contact lenses online. This information will never be shared.

Mr. Mrs. Ms. Dr.		
First Name	**MI**	**Last Name**
Address:		
	Apt:	
City:	**State**	**Zip**
Date of Birth: MM/DD/Yr.	**Age:**	**Gender:** M F

Email:
Phone:
Cell Phone:

Occupation:	**Employer:**

IMPORTANT INSURANCE NFORMATION:

Your vision plan is intended for "eyeglasses or contact lens" exams. This is limited to your prescription, and a screening for eye disorders. *Vision Plans do not cover* medical eye care (floaters, dry eyes, allergy, lazy eye, Vision loss, red eyes, infections and such) or any prescription for Medication.

If you have a pre-existing condition or any disease that affects vision or can cause blindness (cataracts, glaucoma, dry eye, diabetes, high Blood Pressure, cholesterol, etc.) Then your exam will be considered medical Care. These services will be covered by your major medical Insurance. Vision plans do not cover medical eye care.

At the time of Service we require both insurance information.

HIPAA & PRIVACY:

______I have read or been presented with the HIPAA Privacy Policy manual and wish to continue care.

Person responsible for Account:	**Relationship:** Parent Child Self Spouse
Name:	

Please let us know how you where referred:

_ Friend Family _ Mail _Advertisement _ Internet Search _ Insurance

Other:___________________________________

Medical Insurance

Employer	
Insured Name:	

Relationship: Circle one: Self Spouse Child Other

Ins ID#: ______________________ Group# _________________

Insurance Phone Number ( ) --

Vision Insurance

Employer	
Insured Name:	

Insurance:		

- If you do not WRITE DOWN you have Medical Coverage or Vision Plan before service or goods are rendered, we will assume no coverage exists. Our Office with NO EXCEPTIONS will not back file claims, post authorize claims or refund.
- If you discover you have Medical or Vision coverage after professional services or products are rendered, it is your responsibility to file your claim for reimbursement. We will help you file your claim.

I have read and understand the terms and policies of Eye and Vision and allow Eye and Vision Management to file for Insurance payments or collect payment. I certify that the information supplied on this statement Is accurate to the best of my knowledge.

Signed: Date

Please do not hesitate to ask if you have any questions

Personal & Insurance Information: ***Please Complete*** **Date:** ______________________

NAME (Mr./ Mrs., Ms, Dr) ____ DOB: ___________________________

PCP:____________________________________ Date of Last Medical Exam: ______________________________________

Medical History

Do you have **DIABETES?** ☐ YES ☐ NO How many years? ________ Using Medication? ☐ YES ☐ NO
Do you have **HYPERTENSION**? ☐ YES ☐ NO How many years? ________ Using Medication? ☐ YES ☐ NO
Do you have **Cholesterol Problems**? ☐ YES ☐ NO How many years? ________ Using Medication? ☐ YES ☐ NO
Are you **ALLERGIC** to Medications? ☐ YES ☐ NO Which: ____

Medications: (Please list any and all Medication including Over the Counter, Homeopathic, Birth Control or Remedies):

____

____

List all Major Injuries, Surgeries, and Hospitalizations you have had:

____

____

Review Of Systems (please circle):

System	Symptoms		
Constitutional:	Fever, Weight Loss, Appetite	☐ YES	☐ NO
Integumentary:	Skin conditions/ disorders	☐ YES	☐ NO
Neurological:	Headaches, Migraine, Seizures	☐ YES	☐ NO
Endocrine:	Thyroid/ Endocrine gland problem	☐ YES	☐ NO
Ears, Nose Throat:			
Allergies, Sinus, Cough, Dry Throat/Mouth		☐ YES	☐ NO
Respiratory:	Asthma, Emphysema, Bronchitis	☐ YES	☐ NO
Vascular:	Hypertension, Stroke, Heart Pain	☐ YES	☐ NO
Gastrointestinal:	Diarrhea, Constipation	☐ YES	☐ NO
Genitourinary:	Genitals, Kidneys, Bladder	☐ YES	☐ NO
Bones/ Joints:	Rheumat Arthritis, Muscle Pain	☐ YES	☐ NO
Lymphatic/Hematologic:	Anemia, Bleeding	☐ YES	☐ NO
Allergic Immunologic:	Allergies, Immune	☐ YES	☐ NO
Psychiatric:	Depression/Anxiety	☐ YES	☐ NO

Ocular ROS			**Which EYE?**	
Sudden Vision Loss	☐ YES	☐ NO	R	L
Blurred Vision	☐ YES	☐ NO	R	L
Loss of Side Vision	☐ YES	☐ NO	R	L
Double Vision	☐ YES	☐ NO	R	L
Floaters	☐ YES	☐ NO	R	L
Flashes	☐ YES	☐ NO	R	L
Mucus Discharge	☐ YES	☐ NO	R	L
Redness	☐ YES	☐ NO	R	L
Gritty Feeling	☐ YES	☐ NO	R	L
Itching/ Burning	☐ YES	☐ NO	R	L
Tearing/ Watery	☐ YES	☐ NO	R	L
Glare	☐ YES	☐ NO	R	L
Eye Pain/ Discomfort	☐ YES	☐ NO	R	L
Haloes at Night	☐ YES	☐ NO	R	L

____

Family Ocular & Medical History:

			Relationship to you:
Blindness	☐ YES	☐ NO	____________________
Cataracts	☐ YES	☐ NO	____________________
Glaucoma	☐ YES	☐ NO	____________________
Macular Degeneration	☐ YES	☐ NO	____________________
Retinal Disease	☐ YES	☐ NO	____________________
Arthritis	☐ YES	☐ NO	____________________
Cancer	☐ YES	☐ NO	____________________
Diabetes	☐ YES	☐ NO	____________________
High Blood Pressure	☐ YES	☐ NO	____________________
Heart Disease	☐ YES	☐ NO	____________________
Kidney Disease	☐ YES	☐ NO	____________________
Thyroid Disease	☐ YES	☐ NO	____________________

Any Other? Explain: ____

Contact Lens History

Have you ever worn contact lenses?

☐ Yes ☐ No

If yes, what type and when?

____

Are you interested in new contact lenses?

☐ Yes ☐ No

Social: (*ALL information is strictly confidential, you may discuss this part with the doctor*) ☐ Check here to discuss with Doctor

Do you Drive? ☐ YES ☐ NO Do you have difficulty driving? ☐ YES ☐ NO Explain______________________________
Use of tobacco products? ☐ YES ☐ NO Use of alcohol product? ☐ YES ☐ NO Use of Illicit drugs? ☐ YES ☐ NO
Have you been diagnosed / exposed to any Infectious Disease (HIV, TB)? ☐ YES ☐ NO Explain _ ______________________________

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