Focus Eyecare Center

WELCOME TO OUR OFFICE

Today's Date_____

PATIENT INFORMATION

Patient Name_____

Date of Birth_____ Sex M F

Email Address (for office use only)

_____

Social Security Number_____

Street Address_____

City _____ State _____ Zip _____

Home Phone_____

Daytime Phone_____

Cell Phone_____

Spouse's Name_____

Spouse's Date of Birth_____

If patient is under 18, parent's name_____

Employer_____

Occupation_____

Emergency Contact Name_____

Phone Number_____

What hobbies/ sports do you enjoy?_____

HOW DID YOU HEAR ABOUT OUR OFFICE OR WHO REFERRED YOU?_____

_____

INSURANCE INFORMATION

Please present your insurance cards so we can make a copy.

VISION INSURANCE_____

Policyholder's Name_____

Date of Birth_____

Social Security_____

MEDICAL INSURANCE_____

Policyholder's Name_____

Date of Birth_____

Social Security_____

Id#_____

Group#_____

Assignment of Benefits

I agree to pay Focus Eyecare Center and its assigns, for any and all services rendered or expenses incurred. I understand that bills are payable in full upon the rendering of treatment, however, Focus Eyecare Center will bill any applicable insurance as a courtesy. I assign Focus Eyecare Center all benefits due me for services rendered and expenses incurred. I understand that I am financially responsible for all charges not covered by this assignment and agree to pay any remaining balance.

_____

Signature of Patient/ or Guardian **Date**

EYE STYLE

Last eye exam_____

Previous eye doctor_____

Do you wear contact lenses? ☐ No ☐ Yes

If yes, what brand? _____

If no, are you interested in trying contacts? ☐ No ☐ Yes

Do you sleep in your contacts? ☐ No ☐ Yes

What solution do you use? _____

Are you interested in trying colored contacts? ☐ No ☐ Yes

Do you wear non-prescription sunglasses with your contacts? ☐ No ☐ Yes

Do you wear glasses? ☐ No ☐ Yes

☐ All the time ☐ Occasionally

☐ Reading ☐ Driving

Do you wear prescription sunglasses? ☐ No ☐ Yes

Are they polarized? ☐ No ☐ Yes

Are you bothered by glare from any of the following:

☐ Night Driving ☐ Computers

☐ Sunshine ☐ Fluorescent Lights

What do you like most about your current glasses?_____

_____

What do you like least about your current glasses?_____

_____

FAMILY HISTORY

Is there a family history for any of the following: Please check all that apply and list any other family history that we may need to know about.

Relationship to patient

☐ Cataracts _____

☐ Glaucoma _____

☐ Macular Degeneration _____

☐ Retinal Detachment _____

☐ Diabetes _____

☐ Other_____ _____

EYE HEALTH HISTORY

Are you currently using any prescription or non-prescription eye drops? ☐ No ☐ Yes, please list _____

Have you ever had any of the following: (please check all that apply)

- ☐ Cataracts
- ☐ Crossed Eyes
- ☐ Droopy Eyelids
- ☐ Eye Injury
- ☐ Glaucoma
- ☐ Lazy Eye
- ☐ Macular Degeneration
- ☐ Protruding Eyes
- ☐ Refractive Surgery
- ☐ Loss of Vision
- ☐ Blurred Vision
- ☐ Burning Eyes
- ☐ Double Vision
- ☐ Dry Eyes
- ☐ Eye Strain
- ☐ Floaters or Flashes
- ☐ Headaches
- ☐ Itching Eyes
- ☐ Red Eyes
- ☐ Watering Eyes
- ☐ Sandy/Gritty Feeling

MEDICAL HEALTH HISTORY

Date of last medical exam _____

Family Physician _____

Please list medications you are currently taking

Are you allergic to any medications? ☐ No ☐ Yes, please list _____

Review of Systems

Have you ever been diagnosed or treated for any of the following: (please check all that apply)

Integumentary
- ☐ Skin Disease

Neurological
- ☐ Headaches
- ☐ Multiple Sclerosis

Endocrine
- ☐ Thyroid

Immunologic
- ☐ Cancer

Ear/Nose/Mouth/Throat
- ☐ Allergies

Lymphatic/Hematologic
- ☐ Anemia

Psychiatric
- ☐ Anxiety/Depression

Respiratory
- ☐ Asthma

Vascular/Cardiovascular
- ☐ Diabetes
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol

Gastrointestinal
- ☐ Crohn's Disease
- ☐ Reflux

Urinary
- ☐ Bladder/Kidney

Bones/Joints/Muscles
- ☐ Arthritis

Please list any other medical or vision information we should know about.