innovative eye care OPTOMETRIC CORPORATION

WELCOME TO OUR OFFICE

Patient Information

Last Name _____
First Name _____ M.I. _____
Street _____
City _____ State _____
Zip Code _____
Home Phone _____
Cell Phone _____
Work Phone _____
Date of Birth _____ Age _____
S.S.N. _____
Sex M F
Email _____
Employer _____
Occupation _____

Spouse's Name _____
Spouse's Work _____

Emergency Contact _____
Contact Phone _____

Insurance Information

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

Please note that sometimes insurance does NOT cover the Contact Lens Fitting Evaluation

Lifestyle Questions

Do you.....(check box if your answer is yes)

☐ ...work at a computer?
☐ ...think you might benefit from thinner, lighter lenses?
☐ ...spend time outdoors? How much? _____ hours/week
☐ ...have prescription sunwear?
☐ ...prefer not to wear your glasses at times?
☐ ...want information on Laser Vision Correction surgery?
☐ ...have more than one pair of current Rx eyewear?

New Patients

Who may we thank for referring you to our office? (Name) _____

If not referred, how did you choose our office?

☐ Insurance List ☐ Newspaper ☐ Yellow Pages
☐ Saw Sign / Building ☐ Flyer ☐ Web Page _____
☐ Radio ☐ Facebook ☐ Other _____

The information in this confidential case history form is critical to the evaluation of your vision and health.

Patient Medical History

Physician's Name _____

Date of Last Physical Check-Up _____

CURRENT MEDICATIONS (Rx or Over the Counter)
List name of medications including eye drops, vitamins, and birth control pills.

_____

_____

Allergies to medications? ☐ YES ☐ NO

If so, what medications? _____

Have you had any surgeries? ☐ YES ☐ NO

If yes, what kind? _____

Do you use cigarettes/tobacco? ☐ YES ☐ NO

If yes, how much? _____

Do you drink alcohol? ☐ YES ☐ NO

If yes, how much? _____

Have you ever been diagnosed or treated for the following health problems?

	YES	NO
Seasonal Allergies	☐	☐
Arthritis	☐	☐
Blood/Lymph	☐	☐
Bronchitis	☐	☐
Cancer	☐	☐
If yes, what type _____		
Cholesterol	☐	☐
Diabetes	☐	☐
If yes, Type I or Type II		
Digestive	☐	☐
If yes, what type _____		
Ear/Nose/Throat	☐	☐
Endocrine	☐	☐
Eczema/Rashes	☐	☐
Genitourinary	☐	☐
Heart Disease	☐	☐
High Blood Pressure	☐	☐
Integumentary (Skin)	☐	☐
Kidney	☐	☐
Muscle/Bone	☐	☐
Neurological	☐	☐
Psychological	☐	☐
Respiratory	☐	☐
Sinus	☐	☐
Thyroid	☐	☐
Unusual weight loss/gain	☐	☐

Patient Eye History

Date of last Eye Exam _____

By Whom? _____

Have you ever tried contact lenses? ☐ YES ☐ NO

If not, are you interested in wearing? ☐ YES ☐ NO

Do you currently wear contact lenses? ☐ YES ☐ NO

What kind? _____

Solutions used _____

Are you satisfied with the vision and comfort of your contact lenses? ☐ YES ☐ NO

Would you prefer clear contact lenses or colored contact lenses? ☐ Clear ☐ Colored

If you wear bifocals, do the lines or head tilting bother you? ☐ YES ☐ NO

Family Medical/Eye History

Is there a family history of any of the following?
(check all that apply)

	Mother's Side	Father's Side
Blindness	☐	☐
Cataracts	☐	☐
Corneal Problems	☐	☐
Macular Degeneration	☐	☐
Glaucoma	☐	☐
Retinal Problems	☐	☐
Lazy Eye	☐	☐
Diabetes	☐	☐
Heart Disease	☐	☐

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

If your insurance company has not reimbursed our office in full within 60 days, you will be billed for the remaining charges. (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).

Signature_____ Date _____

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