Welcome to
EYES ON MAiN

Our mission is to ensure the utmost quality of life to each and every patient regarding vision and the health of their eyes. To provide each patient with outstanding service, respect, education, and a thoroughness not seen elsewhere. We appreciate your patronage and will work hard to maintain your trust.

Patient Information

Last ______________________________
First ____________________ MI ____________
Street ______________________________
City ______________ State ______________
Zip Code ______________________________

Email Address* ______________________
Cell/Home Phone ______________________
Work Phone ______________________
Preferred contact: Email / Cell / Home / Work

Patient's SSN ______________________
Employer (or School) ______________________
Occupation (or Grade)______________________
Spouse/Parent/Partner ______________________
Spouse/Parent/Partner Work ______________________
Date of Birth ____________________ Age________
Sex M F
What is the major purpose of this visit?

____

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?
6 Another Dr.
6 Insurance List
6 Saw Sign/Building
6 Newspaper/Radio/TV
6 Yellow Pages: Which directory? ______________
6 Web Page: Which Web Site? __________
6 Other ______________________________
*used only for correspondence from our office

Today's Date ______________________

Insurance Information

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

Vision Insurance______________________
Subscriber Name______________________
Subscriber Ins.ID#______________________
Subscriber Birth Date______________________

Primary Medical Insurance______________________
Subscriber Name______________________
Subscriber Ins. ID#______________________
Subscriber Birth Date______________________

Subscriber Address:______________________
Subscriber City/State/Zip:______________________
Subscriber Phone: ______________________

Do you participate in a flex spending account?
6 Yes 6 No
How will you settle your account today?
6 Cash 6 Check 6 Credit Card

Lifestyle Questions

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

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

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

6 Blurry Vision
6 Eye Infections
6 Trouble seeing at night
6 Lazy Eye
6 Crossed eye/Eye turn
6 Double Vision
6 Corneal Abrasions
6 Eye Injury
6 Cataracts
6 Floaters/Spots
6 Glaucoma
6 Flash of light
6 Headaches (Frequent/Occasional)
6 Iritis/Uveitis
6 Uncomfortable glasses
6 Dry Eyes
6 Macular Degeneration
6 Burning
6 Retinal Detachment
6 Itchiness
6 Sun Sensitivity
6 Grittiness

6 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? 6 Yes 6 No
If so, what medications?____________________

Have you had any surgeries? 6 Yes 6 No
Do you use cigarettes/tobacco, alcohol, or other substances? 6 Yes 6 No

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

6 Allergies
6 Blood/Lymph
6 Cancer
6 Diabetes
6 Ears/Nose/Throat
6 Eczema/Rashes
6 Fevers
6 High Blood Pressure
6 Kidney
6 Neurological
6 Respiratory
6 Throat Infections
6 Unusual weight losses/gains
6 Arthritis
6 Bronchitis
6 Cholesterol
6 Digestive
6 Endocrine
6 Fatigue
6 Genitourinary
6 Integamentory (Skin)
6 Muscle/Bone
6 Psychological
6 Sinus
6 Thyroid

Patient Eye History

Date of Last Eye Exam ____________________
By Whom?________________________

Have you ever tried contact lenses? 6 Yes 6 No

Do you currently wear contact lenses? 6 Yes 6 No
What kind? ____________________
Solutions used ____________________

Are you satisfied with the vision and comfort of your contact lenses? 6 Yes 6 No

Do you sleep in your contact lenses?
6 Yes (___ days/week) 6 No
Have you been satisfied with your current progressive multifocals? 6 Yes 6 No

Have you used Transition Lenses?
6 Yes 6 No

Family Medical/Eye History (Check all that apply)

Is there a family medical history of any of the following:

		Relationship (Mother's or Father's side)
Blindness	6	__________
Cataracts	6	__________
Corneal Problems	6	__________
Diabetes	6	__________
Glaucoma	6	__________
Heart Disease	6	__________
Lazy Eye	6	__________
Macular Degeneration	6	__________
Retinal Problems	6	__________

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

If your insurance company has not reimbursed our office in full within 90 days, you will be billed directly by EYES ON MAiN. (If by mistake your insurance company sends the payment check to us, we will of course refund any amounts due to you.) Patient balances over 90 days will be collected by **CREDIT ASSOCIATES** with associated fees and interest.

Your signature below also verifies that you understand EYES ON MAiN financial policy and have been presented a copy of EYES ON MAiN notice of privacy policy complying with HIPPA regulations.

Signature of Guarantor ______________________________ Date: ____________________

We appreciate you choosing EYES ON MAIN and greatly appreciate the referral of your family and friends.