Welcome to Eyes on Main

Patient Information

Last _____

First _____MI _____

Mailing _____

City/State/Zip _____

Cell/Home _____

Work/Other _____

Email _____

Preferred: **Email / Cell / Home / Work**

Sex: **M F** SSN: _____

Age: _____ DOB: _____

Employer (or school): _____

Occupation (or grade): _____

Emergency Contact: _____

Phone Number: _____

What is the major purpose of this visit?

_____

Any Problems with your current glasses/contact lenses?

_____

Who may we thank for referring you to our office?

_____

If not referred, how did you choose our office?

- ☐ Another Doctor
- ☐ Insurance Provider List
- ☐ Saw Sign/Building
- ☐ Online: Which web site?: _____
- ☐ Other: _____

Insurance Information

Vision Insurance: _____
Insurance ID#: _____
Subscriber Name: _____
Subscriber DOB: _____

Medical Insurance:_____
Insurance ID#: _____
Subscriber Name: _____
Subscriber DOB: _____

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

Do you have a flex spending account? **Yes** **No**

How will you settle your account today?
Cash / Check / Card / Care Credit

Lifestyle

Do you….(check all that apply)

- ☐ work at a computer?
- ☐ feel you might benefit from thinner, lighter, lenses?
- ☐ have interest in trying the latest contact lens?
- ☐ spend time outdoors? Approx. _____ hours/week
- ☐ have prescription sun wear?
- ☐ prefer not to wear your glasses at times?
- ☐ want information on LASIK?
- ☐ have more than 1 pair of *current* Rx eyewear?
- ☐ have children?
- ☐ have family members in need of eye care?

Have you ever experienced, been diagnosed or treated for any of the following? (check all that apply)

- ☐ Blurry Visio
- ☐ Eye Infections
- ☐ Lazy Eye
- ☐ Trouble Seeing at Night
- ☐ Crossed Eyed/Eye Turn
- ☐ Corneal Abrasions
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Headaches (Frequent/Occasional)
- ☐ Double Vision
- ☐ Other:
- ☐ Eye Injury
- ☐ Floaters/Spots
- ☐ Flashes of Light
- ☐ Retinal Detachment
- ☐ Iritis/Uveitis
- ☐ Dry Eyes
- ☐ Itchiness/Grittiness
- ☐ Burning
- ☐ Uncomfortable Glasses/Contacts
- ☐ Sun Sensitivity

Medical History

Name of primary care physician: _____
Date of last physical check-up: _____

Current medications (Rx & over the counter, incl. eye drops, vitamins & birth control): _____
_____
_____

Are you pregnant or breastfeeding? **Yes** **No**

Allergies to medications? **Yes** **No**
If so, what medications? _____
_____

Have you had any surgeries? **Yes** **No**

Do you use….
- ☐ Cigarettes/Tobacco If yes, how often?_____
- ☐ Alcohol If yes, how often?_____
- ☐ Other substances If yes, how often?_____

Have you ever been diagnosed or treated for the following health problems? (check all that apply)

- ☐ Allergies
- ☐ Blood/Lymph
- ☐ Cancer
- ☐ Diabetes
- ☐ Ears/Nose/Throat
- ☐ Eczema/Rashes
- ☐ Fevers
- ☐ High Blood Pressure
- ☐ Kidney
- ☐ Neurological
- ☐ Respiratory
- ☐ Throat Infections
- ☐ Unusual Weight Loss/Gain
- ☐ Arthritis
- ☐ Bronchitis
- ☐ Cholesterol
- ☐ Digestive
- ☐ Endocrine
- ☐ Fatigue
- ☐ Genitourinary
- ☐ Integumentary(skin)
- ☐ Muscle/Bone
- ☐ Psychological
- ☐ Sinus
- ☐ Thyroid
- ☐ Other:

Eye History

Date of last eye exam: _____
By whom? _____

Have you tried contact lenses? **Yes** **No**

Do you currently wear contact lenses? **Yes** **No**
If yes, what type/brand? _____
Solutions used: _____

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

Do you sleep in your contact lenses? **Yes** **No**
If yes, how many days/week? _____

If you wear multifocal glasses, are you satisfied with your current progressives? **Yes** **No**

Have you tried Transition lenses? **Yes** **No**

Family Medical & Eye Health History

Family history of any of the following: (check all the apply)

	Relationship
☐ Blindness	
☐ Cataracts	
☐ Corneal Problems	
☐ Glaucoma	
☐ Lazy Eye	
☐ Macular Degeneration	
☐ Retinal Problems	
☐ Diabetes	
☐ Heart Disease	
☐ High Blood Pressure	
☐ Other:	

Please be advised that if you are utilizing insurance coverage for today's visit, that is a contract between you and your insurance company, not Eyes on Main. Any balance outstanding longer that 90 days will be billed directly to you, by Eyes on Main. If, by mistake, we receive payment from your insurance, we will refund any amounts due to you.

Outstanding patient balances over 90 days will be collected by **Credit Associates** with associated fees and interest.

You signature below verifies that you understand Eyes on Main's financial policy and have been presented a copy of Eyes on Main's notice of privacy 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!