20/20 eyecare centers

Today's Date: _____

Patient Information

Last _____Nickname_____

First _____ _____MI _____

Street or PO _____

City _____

State _____Zip Code _____

Home phone _____

Daytime phone _____

Cell phone _____Ok to Text: Yes

If texting ok: Cell Carrier

Email address: _____

Date of birth _____

Patient's SSN _____

Gender: Female

Employer (or school) _____

Occupation (or grade) _____

Spouse or parent name _____

Spouse or parent's work _____

Race: ☐ American Indian/Alaskan Native ☐ Asian
☐ Black/African American ☐ Hispanic
☐ Native Hawaiian/Pacific Islander ☐ White

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Language spoken: ☐ English ☐ Spanish

What is the major purpose of this visit?

_____

Any problems with your current contact lenses or glasses?

_____

I have read and understand my privacy rights:
Signature: _____
Date: _____
I hereby authorize my insurance benefits to be paid directly to the physician and I agree to be financially responsible for any non-covered service including deductibles and co-pays. I am also aware that I am responsible for any costs incurred in collection of any non-assigned fees. I authorize the physician to release any information required to process my insurance claims.
Signature: _____
Date : _____

Welcome to our office
The mission of 20/20 Eyecare Centers is to provide our patients with the highest quality eye care and materials in a friendly and professional atmosphere. In everything we do we shall strive to communicate this.

Insurance Information

Please note that insurance does NOT cover the Contact Lens evaluation or fitting.

Primary Vision insurance_____

Subscriber name _____

Subscriber ID_____

Subscriber birth date _____

Secondary Vision insurance_____

Subscriber name _____

Subscriber ID_____

Subscriber birth date _____

Primary Medical Insurance_____

Subscriber name _____

Subscriber ID_____

Subscriber birth date _____

Secondary Medical Insurance_____

Subscriber name _____

Subscriber ID_____

Subscriber birth date _____

Do you participate in a flex spending account?
☐ Yes ☐ No

How will you settle your account today?
☐ CASH ☐ CHECK ☐ CREDIT CARD

VERY IMPORTANT! NEW PATIENTS ONLY:
Who may we thank for referring you to our office?

Name of friend relative _____

If not referred, how did you choose our office?
☐ Another Dr._____
☐ Insurance list
☐ Saw sign or building
☐ Newspaper/radio/TV
☐ Yellow Pages: which directory?_____
☐ Web Page: which site?_____
Other_____
_____

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

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) _____

_____

Do you have any allergies to medications? ☐YES ☐NO
If so, what medications? _____

_____

Any other allergies? _____
Are you pregnant or have you been pregnant in the last 3 months? ☐YES ☐NO
Have you had any surgeries? ☐NO ☐YES _____
Do you use tobacco? ☐Current ☐Former ☐Never
Do you use alcohol? ☐Current ☐Former ☐Never
Or other substances? ☐Current ☐Former ☐Never

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

	Yes	No
Allergies	Y ☐	N ☐
Arthritis	Y ☐	N ☐
Blood/Lymph	Y ☐	N ☐
Bronchitis	Y ☐	N ☐
Cancer	Y ☐	N ☐
Cholesterol	Y ☐	N ☐
Diabetes	Y ☐	N ☐
Digestive	Y ☐	N ☐
Ears/Nose/Throat	Y ☐	N ☐
Endocrine	Y ☐	N ☐
Eczema/Rashes	Y ☐	N ☐
Fatigue	Y ☐	N ☐
Fevers	Y ☐	N ☐
Genitourinary	Y ☐	N ☐
Heart Problems	Y ☐	N ☐
High Blood Pressure	Y ☐	N ☐
Integumentary (Skin)	Y ☐	N ☐
Kidney	Y ☐	N ☐
Muscle/Bone	Y ☐	N ☐
Neurological	Y ☐	N ☐
Psychological	Y ☐	N ☐
Respiratory	Y ☐	N ☐
Sinus	Y ☐	N ☐
Throat Infections	Y ☐	N ☐
Thyroid	Y ☐	N ☐
Unusual weight losses/gains	Y ☐	N ☐

Other _____

Patient Eye History

Date of Last Eye Exam _____

By Whom? _____

If you wear bifocals, do the lines or head tilting bother you? ☐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
Have you ever tried contact lenses? ☐YES ☐NO
Would you like to try contact lenses? ☐YES ☐NO
Would you prefer clear contact lenses or colored contact lenses? ☐CLEAR ☐COLORED

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

- ☐ Blurry vision
- ☐ Cataracts
- ☐ Crossed eye/Eye turn
- ☐ Eye infections
- ☐ Flash of light
- ☐ Glaucoma
- ☐ Headaches
- ☐ Itchiness
- ☐ Macular Degeneration
- ☐ Retinal Detachment
- ☐ Tearing
- ☐ Uncomfortable glasses
- ☐ Other eye disorders
- ☐ Burning
- ☐ Corneal abrasions
- ☐ Double vision
- ☐ Eye injury
- ☐ Floaters/Spots
- ☐ Grittiness
- ☐ Iritis/Uveitis
- ☐ Lazy Eye
- ☐ Allergy Eye
- ☐ Sunlight sensitivity
- ☐ Trouble seeing at night
- ☐ Dry eye

___ other:_____

Family Medical/Eye History (Check all that apply)

Is there a ***family medical history*** of any of the following? (any blood relatives)

NO YES (please check boxes & indicate relationship)
(Mothers or Fathers side)

- ☐ ☐ Diabetes _____
- ☐ ☐ High Blood Pressure _____
- ☐ ☐ Cancer _____
- ☐ ☐ Thyroid Conditions _____
- ☐ ☐ Glaucoma _____
- ☐ ☐ Cataracts _____
- ☐ ☐ Blindness _____
- ☐ ☐ Macular Degeneration _____
- ☐ ☐ Corneal Problems _____
- ☐ ☐ Lazy Eye _____
- ☐ ☐ Retinal Problems _____

Lifestyle Questions

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

- ☐ ..think you might benefit from thinner, lighter lenses?
- ☐ ..have interest in the latest contact lens designs?
- ☐ ..spend time outdoors? How much? ___hrs/week
- ☐ ..work at a computer?
- ☐ ..have prescription sun wear?
- ☐ ..prefer not to wear your glasses at times?
- ☐ ..want information on Lasik Surgery?
- ☐ ..have more than one pair of current Rx eyewear?
- ☐ ..have children in the home?
- ☐ ..have family members in need of Eyecare?
- ☐ ..have an interest in pre-appointing your next exam?