WELCOME TO OUR OFFICE

Patient Information

Today's Date ______________________________
Reason for Visit: ______________________________
____
Last Name ______________________________
First Name ______________________ MI ________
Street ______________________________
City ______________________ State __________
Zip Code ______________________________
Home Phone (______) ______________________
Cell Phone (______) ______________________
Patient's SSN ______________________________
Date of Birth _____/_____/________ Age ________
Gender ❑ Male ❑Female
Employer (or School) ______________________
Occupation (or Grade) ______________________
Spouse (or Parent's Name) __________________

Email Address ______________________________
Date of Last Exam: ______________________________
By Whom? ______________________________

Who may we thank for referring you to our office?
Name of friend or relative ______________________

If not referred, how did you choose our office?

- ❑ Another Dr.
- ❑ Insurance List
- ❑ Saw Sign/Building
- ❑ Newspaper/Radio/TV
- ❑ Yellow Pages
- ❑ Web Page
- ❑ Other ______________________________

Insurance Information

Please note that insurance may NOT cover the Contact Lens Evaluation.

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?
❑ NO ❑ YES
How will you settle your account today?
❑ Cash ❑ Check ❑ Credit Card

Patient Medical History

Name of Family Physician ______________________
Town/City ______________________________
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? ❑ NO ❑ YES

If YES, what medications? ______________________
____

Have you had any surgeries? ❑ NO ❑ YES

If YES, what surgeries? ______________________
____

Do you use cigarettes/tobacco, alcohol, or other substances? ❑ NO ❑ YES

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

	NO	YES
Allergies	❑	❑
Arthritis	❑	❑
Blood/Lymph	❑	❑
Bronchitis	❑	❑
Cancer	❑	❑
Cholesterol	❑	❑
Digestive	❑	❑
Ears/Nose/Throat	❑	❑
Endocrine	❑	❑
Eczema/Rashes	❑	❑
Fatigue	❑	❑
Fevers	❑	❑
Genitourinary	❑	❑
High Blood Pressure	❑	❑
Integumentary (Skin)	❑	❑
Kidney	❑	❑
Muscle/Bone	❑	❑
Neurological	❑	❑
Psychological	❑	❑
Respiratory	❑	❑
Sinus	❑	❑
Throat Infections	❑	❑
Thyroid	❑	❑
Unusual weight losses/gains	❑	❑

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	❑ ____________
Cataracts	❑ ____________
Corneal Problems	❑ ____________
Diabetes	❑ ____________
Glaucoma	❑ ____________
Heart Disease	❑ ____________
Lazy Eye	❑ ____________
Macular Degeneration	❑ ____________
Retinal Problems	❑ ____________

Eye Conditions

Have you ever been diagnosed with any of the following conditions? Conditions previously noted by your doctor will be…

	NO	YES
Cataract	❑	❑
Age-related Macular Degen	❑	❑
Glaucoma	❑	❑
Diabetes	❑	❑
Diabetic Retinopathy	❑	❑
Dry Eye	❑	❑
Eye infection/inflammation/allergy	❑	❑
Floaters/Flashes of Light	❑	❑
Iritis/Uveitis	❑	❑
Retinal Defects/Degenerations	❑	❑

Other (Please Describe):____________________

Eye Concerns

Are you having any of the following eye concerns?

	NO	YES
Redness	❑	❑
Burning	❑	❑
Itching	❑	❑
Tearing	❑	❑
Discharge	❑	❑

Other (Please Describe):____________________

Vision Concerns

Are you having any of the following vision concerns?

	NO	YES
Blurred Vision	❑	❑
Eyestrain	❑	❑
Eye Pain	❑	❑
Severe Sensitivity to Lights	❑	❑
Headache	❑	❑
Poor Night Vision	❑	❑
Bothersome Night Glare	❑	❑
Double Vision	❑	❑
Total Loss of Vision	❑	❑

Other (Please Describe):____________________

Vision Correction

Please tell us about your current corrective lenses. **(Please circle your choice):**

1. What corrective lenses are you mainly using for **far/distance** vision activities?

None / Eyeglasses / Contact Lenses

2. Describe the quality of your **far/distance** vision activities:

Acceptable / May need improvement / Blurred

3. What corrective lenses are you mainly using for **near/reading** vision activities?

None / Eyeglasses / Contact Lenses / Contact Lenses with Glasses

4. Describe the quality of your **near/reading** vision activities:

Acceptable / May need improvement / Blurred

5. What corrective lenses are you mainly using for **computer** vision activities?

None / Eyeglasses / Contact Lenses / Contact Lenses with Glasses

6. Describe the quality of your **computer** vision activities:

Acceptable / May need improvement / Blurred

Computer Demands

Do you have any of the following computer demands on your vision?

	NO	YES
Computer use for extended periods	❑	❑
Unusual ergonomics demands	❑	❑
Must simultaneously view paperwork and computer	❑	❑
Use of laptop	❑	❑
Use of multiple desktop monitors	❑	❑

Other (Please Describe):_______________________________

Performance & Outdoor

Vision Performance: Do you have any of these vision performance problems?

	NO	YES
Poor reading skills or low reading	❑	❑
Inconsistent sports vision	❑	❑
Slowness when shifting focus	❑	❑
Difficulty with 3-D images, movies, or TV	❑	❑

Other (Please Describe):_______________________________

Outdoor Demands: Describe any special demands

	NO	YES
Extended night driving	❑	❑
Outdoors in direct UV exposure	❑	❑
Read in outdoor settings	❑	❑
Irritated contact lenses when outdoors	❑	❑

Other (Please Describe):_______________________________

Eyeglass Desires

Do you have any of the following desires for your glasses?

	NO	YES
Replace uncomfortable, broken, or lost eyeglasses	❑	❑
Need extra eyeglasses for special activities	❑	❑
Interest in specific fashion or brands	❑	❑
Would like thinner, lighter lenses	❑	❑
Reduction of glare	❑	❑

Other (Please Describe):_______________________________

Purchasing Plans

Do you plan to purchase any of the following ?

	NO	YES
New Eyeglasses	❑	❑
Prescription Sunglasses	❑	❑
Non-prescription Sunglasses	❑	❑
Computer Eyeglasses	❑	❑
Reading Eyeglasses	❑	❑
Sport Eyeglasses	❑	❑
New Supply of Contact Lenses	❑	❑

Other (Please Describe):_______________________________

Interests

Are you interested in any of the following?

	NO	YES
New contact lens fitting	❑	❑
New technology or more Comfortable contact lenses	❑	❑
One-day use contact lenses	❑	❑
Contact lenses of a different replacement period	❑	❑
Contact lenses for safe overnight	❑	❑
Corneal-reshaping contact lenses	❑	❑
Vision therapy	❑	❑
Laser vision correction	❑	❑

Other (Please Describe):_______________________________

Financial Acknowledgement

Please be advised if you are using insurance benefits for today's visit, this is a contract between you and your insurance company…not Midtown Optometry.
If your insurance company has not reimbursed our office in full within 60 days, you will be responsible for payment.

By signing and dating below, you have read and understand your financial responsibility.

Signature_______________________________Date_______

Thank you !!