

WELCOME TO OUR OFFICE



INSIGHT EYECARE

Patient Information

Last _____
First _____ MI _____
Street _____
City _____ State _____
Zip Code _____
Home Phone _____
Work Phone _____
Cell Phone _____
Email Address _____
How do you prefer to be contacted?
(Indicate #1 and #2 Choice):
Home # ___ Work # ___ Cell # ___ Text ___ Email ___
Patient's SSN _____
Race _____
Sex M F
Patient's Date of Birth _____
Employer (or School) _____
Occupation (or Grade) _____
Marital Status _____
Spouse (or Parent's) Name _____
Spouse (or Parent's) Work _____
Spouse (or Parent's) Date of Birth _____

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?
 Another Dr.
 Insurance List
 Saw Sign/Building
 Internet Search

At Insight Eyecare, we strive to help our patients obtain exceptional vision at all stages of life by maintaining eye health and providing the latest options to enhance vision.

Insurance Information

Please note that medical insurance does NOT cover the Contact Lens Evaluation.

Primary Medical Insurance _____
Vision Insurance _____
Subscriber Name _____
Subscriber SSN _____
Subscriber Birth Date _____

Do you participate in a flex spending/Health Savings Account? _____
(Can be used towards exam and optical orders)

Lifestyle Questions

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

- ..work at a computer? If yes, how many hours per day _____
- ..think you might benefit from thinner, lighter lenses?
- ..have interest in trying the latest contact lens designs?
- ..think you have trouble with night driving or glare?
- ..spend time outdoors? How much? ___Hrs/week
- ..have prescription sunwear?
- ..prefer not to wear your glasses at times?
- ..want information on Laser Vision Correction surgery?
- ..have more than 1 pair of current Rx eyewear?
- ..have family members/children in need of eyecare?

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

- | | |
|--|--|
| <input type="checkbox"/> Blurry Vision | <input type="checkbox"/> Burning |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Corneal Abrasions |
| <input type="checkbox"/> Crossed eye/Eye turn | <input type="checkbox"/> Double Vision |
| <input type="checkbox"/> Eye Infections | <input type="checkbox"/> Eye Injury |
| <input type="checkbox"/> Flash of light | <input type="checkbox"/> Floaters/Spots |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Grittiness |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Iritis/Uveitis |
| <input type="checkbox"/> Itchiness | <input type="checkbox"/> Lazy Eye |
| <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Occasional dryness |
| <input type="checkbox"/> Retinal Detachment | <input type="checkbox"/> Sunlight Sensitivity |
| <input type="checkbox"/> Tearing | <input type="checkbox"/> Trouble seeing at night |
| <input type="checkbox"/> Uncomfortable glasses | |
| <input type="checkbox"/> Other eye disorders _____ | |

Contact Lenses

Have you ever tried contact lenses? Yes No
Do you currently wear contact lenses? Yes No
What kind? _____
Are you satisfied with the vision and comfort of your contact lenses? Yes No

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 _____		
Clinic Name _____		
Clinic Phone _____		
Pharmacy Name/Location _____		

Height and Weight (Must Have) _____		
Are you currently pregnant or nursing? _____		
Have you had any eye surgeries? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, explain: _____		
Have you ever been diagnosed or treated for the following health problems?		
	Yes	No
Allergies Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular		
Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Constitutional		
Fevers	<input type="checkbox"/>	<input type="checkbox"/>
Unusual weight losses/gains	<input type="checkbox"/>	<input type="checkbox"/>
Ears/Nose/Throat		
Sinus	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory		
Asthma/COPD	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Gastrointestinal		
Crohn's	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers/Reflux	<input type="checkbox"/>	<input type="checkbox"/>
Genitourinary		
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Prostate/ Ovarian Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Muscle/Bone		
Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Muscle or Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>
Integumentary (Skin)		
Skin Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Rashes	<input type="checkbox"/>	<input type="checkbox"/>
Neurological/Psychiatric		
Headaches/Migraines	<input type="checkbox"/>	<input type="checkbox"/>
Depression/Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine		
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Blood/Lymph		
Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>
Cancer (Explain) _____		
Any Other Condition _____		

Medications
Current Medications (Rx or Over the Counter) (List name of medications including eye drops, vitamins, & birth control pills)

Allergies to Medications? <input type="checkbox"/> Yes <input type="checkbox"/> No
If so, what kind? _____

Family Medical/Eye History (Check all that apply)	
Is there a family medical history of any of the following:	
<input type="checkbox"/> No	<input type="checkbox"/> Yes (Please check boxes)
	Relationship
	(Mother's or Father's side)
Blindness	<input type="checkbox"/> _____
Cataracts	<input type="checkbox"/> _____
Corneal Problems	<input type="checkbox"/> _____
Diabetes	<input type="checkbox"/> _____
Glaucoma	<input type="checkbox"/> _____
Heart Disease	<input type="checkbox"/> _____
Lazy Eye	<input type="checkbox"/> _____
Macular Degeneration	<input type="checkbox"/> _____
Retinal Problems	<input type="checkbox"/> _____
Cancer	<input type="checkbox"/> _____
High Blood Pressure	<input type="checkbox"/> _____
Strokes	<input type="checkbox"/> _____

Do you use cigarettes?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Former Smoker?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you use tobacco?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you drink alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please be advised if you are using insurance coverage for today's visit, this is a contract between you and your insurance company...not Insight Eyecare.	
If your insurance company has not reimbursed our office in full within 90 days, you may be responsible for providing payment in full to Insight Eyecare.	