

The Eye Studio, PC

Welcome To Our Office

Welcome to The Eye Studio, PC. Thank you for choosing us for your eyecare needs. We are delighted to have you as a patient and appreciate the confidence you placed in us. Please take a moment to complete the following information. Any information we already have on file will appear on this form. Please review all completed areas to ensure that the information we have is current and accurate. If you have any questions, please do not hesitate to ask.

Mr. Miss Mrs. Ms.

Male Female

First Name MI Last Name Preferred Name

Street Address City State Zip

Social Security Number Date of Birth Home Phone - Include Area Code Work Phone

Email Address Spouse or Parent(s) Name Person Responsible for Account

Emergency Contact Emergency Phone Relationship

How were you referred to our office?

Phone Book School Advertisement Patient (Please Name) _____
 Insurance Listing Drive by Other _____ Doctor (Please Name) _____

PRIMARY INSURANCE INFORMATION

Name and Address of Primary Insurance Company City State Zip

M F

Insured's First Name MI Insured's Last Name

Insured's Identification Number Group Number Insured's Date of Birth

Patient Relationship to Insured

Self Spouse Child Other

Patient Status

Single Married Other

Full Time Student Part Time Student Employed

SECONDARY INSURANCE INFORMATION

Name and Address of Secondary Insurance Company City State Zip

M F

Insured's First Name MI Insured's Last Name

Insured's Identification Number Group Number Insured's Date of Birth

Patient Relationship to Insured

Self Spouse Child Other

Please Read:

In order to control the cost of billing, we ask that the patient's portion is paid at the time services are rendered unless other arrangements are made in advance. We would rather control billing costs than be forced to raise our fees. All professional services and material are charged to the patient. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Accounts 90 days old are subject to collection fees. There will be a service charge on all returned checks.

Payment from my insurance is to be paid directly to . I understand that will be billed as my primary insurance. I understand that billing any secondary insurance is my responsibility. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed.

Signature

Date

Name _____

The Eye Studio, PC

PATIENT HISTORY AND INFORMATION

PRIMARY CARE PHYSICIAN

Primary Care Physician and Clinic Name _____

Address of Primary Care Physician _____

City _____

State Zip _____

Phone _____

REFERRING PHYSICIAN

Referring Physician and Clinic Name _____

Address of Referring Physician _____

City _____

State Zip _____

Phone _____

HEALTH HISTORY

What is the main reason for today's exam ? _____ When was your last exam ? _____

When was your last health exam ? _____

Past Illnesses or Injuries: _____

Past Surgeries: _____

Current Medications: _____

Current Eye Drops: _____

Medicines that cause reactions or sensitivities: _____

Specific Allergies: _____

EYE HISTORY

Glaucoma	<input type="radio"/> Yes <input checked="" type="radio"/> No	Dryness	<input type="radio"/> Yes <input checked="" type="radio"/> No	Strabismus (Crossed Eyes)	<input type="radio"/> Yes <input checked="" type="radio"/> No
Cataract	<input type="radio"/> Yes <input checked="" type="radio"/> No	Excess Tearing/Watering	<input type="radio"/> Yes <input checked="" type="radio"/> No	Blurred Vision Distance	<input type="radio"/> Yes <input checked="" type="radio"/> No
Macular Degeneration	<input type="radio"/> Yes <input checked="" type="radio"/> No	Eye Pain or Soreness	<input type="radio"/> Yes <input checked="" type="radio"/> No	Blurred Vision Near	<input type="radio"/> Yes <input checked="" type="radio"/> No
Retinal Detachment	<input type="radio"/> Yes <input checked="" type="radio"/> No	Foreign Body Sensation	<input type="radio"/> Yes <input checked="" type="radio"/> No	Distorted Vision (halos)	<input type="radio"/> Yes <input checked="" type="radio"/> No
Color Blindness	<input type="radio"/> Yes <input checked="" type="radio"/> No	Infection of Eye or Lid	<input type="radio"/> Yes <input checked="" type="radio"/> No	Double Vision	<input type="radio"/> Yes <input checked="" type="radio"/> No
Headaches	<input type="radio"/> Yes <input checked="" type="radio"/> No	Itching	<input type="radio"/> Yes <input checked="" type="radio"/> No	Floaters or Spots	<input type="radio"/> Yes <input checked="" type="radio"/> No
Glare/Light Sensitivity	<input type="radio"/> Yes <input checked="" type="radio"/> No	Mucous Discharge	<input type="radio"/> Yes <input checked="" type="radio"/> No	Fluctuating Vision	<input type="radio"/> Yes <input checked="" type="radio"/> No
Tired Eyes	<input type="radio"/> Yes <input checked="" type="radio"/> No	Drooping Eyelid	<input type="radio"/> Yes <input checked="" type="radio"/> No	Loss of Vision	<input type="radio"/> Yes <input checked="" type="radio"/> No
Amblyopia (Lazy Eye)	<input type="radio"/> Yes <input checked="" type="radio"/> No	Redness	<input type="radio"/> Yes <input checked="" type="radio"/> No	Loss of Side Vision	<input type="radio"/> Yes <input checked="" type="radio"/> No
Burning	<input type="radio"/> Yes <input checked="" type="radio"/> No	Sandy or Gritty Feeling	<input type="radio"/> Yes <input checked="" type="radio"/> No		

GENERAL HEALTH CONDITION

Fever	<input type="radio"/> Yes <input checked="" type="radio"/> No	Respiratory (Asthma)	<input type="radio"/> Yes <input checked="" type="radio"/> No	Anxiety or Depression	<input type="radio"/> Yes <input checked="" type="radio"/> No
Weight Loss	<input type="radio"/> Yes <input checked="" type="radio"/> No	Gastrointestinal	<input type="radio"/> Yes <input checked="" type="radio"/> No	Endocrine (Thyroid, Diabetes)	<input type="radio"/> Yes <input checked="" type="radio"/> No
Other Symptoms	<input type="radio"/> Yes <input checked="" type="radio"/> No	Kidney	<input type="radio"/> Yes <input checked="" type="radio"/> No	Blood/Lymph	<input type="radio"/> Yes <input checked="" type="radio"/> No
Ears, Nose, Throat	<input type="radio"/> Yes <input checked="" type="radio"/> No	Muscles, Bones, Joints	<input type="radio"/> Yes <input checked="" type="radio"/> No	Allergic	<input type="radio"/> Yes <input checked="" type="radio"/> No
Cardiovascular (high blood pressure etc.)	<input type="radio"/> Yes <input checked="" type="radio"/> No	Skin	<input type="radio"/> Yes <input checked="" type="radio"/> No	Are you?	<input type="checkbox"/> Pregnant
Neurological (Multiple Sclerosis)	<input type="radio"/> Yes <input checked="" type="radio"/> No				<input type="checkbox"/> Nursing

FAMILY HISTORY

Amblyopia (Lazy Eye)	<input type="radio"/> Yes <input checked="" type="radio"/> No	Retinal Detachment	<input type="radio"/> Yes <input checked="" type="radio"/> No	High Blood Pressure	<input type="radio"/> Yes <input checked="" type="radio"/> No
Blindness	<input type="radio"/> Yes <input checked="" type="radio"/> No	Strabismus (Eye Turn)	<input type="radio"/> Yes <input checked="" type="radio"/> No	Kidney Disease	<input type="radio"/> Yes <input checked="" type="radio"/> No
Cataract(s)	<input type="radio"/> Yes <input checked="" type="radio"/> No	Arthritis	<input type="radio"/> Yes <input checked="" type="radio"/> No	Lupus	<input type="radio"/> Yes <input checked="" type="radio"/> No
Color Blindness	<input type="radio"/> Yes <input checked="" type="radio"/> No	Cancer	<input type="radio"/> Yes <input checked="" type="radio"/> No	Stroke	<input type="radio"/> Yes <input checked="" type="radio"/> No
Glaucoma	<input type="radio"/> Yes <input checked="" type="radio"/> No	Diabetes	<input type="radio"/> Yes <input checked="" type="radio"/> No	Thyroid Disease	<input type="radio"/> Yes <input checked="" type="radio"/> No
Macular Degeneration	<input type="radio"/> Yes <input checked="" type="radio"/> No	Heart Disease	<input type="radio"/> Yes <input checked="" type="radio"/> No	Others	<input type="radio"/> Yes <input checked="" type="radio"/> No

Name _____

The Eye Studio. PC MEDICAL HISTORY QUESTIONNAIRE

SOCIAL HISTORY

Current Occupation : _____ Years _____ Employer _____

SPECTACLE LENS HISTORY

Do you use a computer? Yes No How many hours/day? _____ Distance from Computer? _____

Do you drive? Yes No Mileage to work each way? _____ Do you have glare problems? Yes No

Do you have visual difficulty when driving? Yes No

Do you have problems with night vision? Yes No

Do you currently wear glasses ? Yes No Since _____

Type of glasses Full Time Part Time Distance Close

Glasses Owned

Single Vision Bifocals Trifocals Back-up Glasses Safety Glasses Sports Glasses Progressive

Have you had trouble in the past with glasses? Yes No _____

Do you wear sunglasses? Yes No Are your sun glasses your current prescription ? Yes No

SPECIAL EYEWEAR NEEDS

Computer (special prescriptions, special anti-glare tints or coatings) Safety Glasses (gardening, woodworking, welding)
 Occupational (mechanics, plumbers, pilots) Sports/Hobbies (racquet sports, motorcycle)

CONTACT LENS HISTORY

Have you ever tried to wear contact lenses? Yes No Reason for stopping? _____

Do you currently wear contact lenses? Yes No Since _____

If not a contact lens wearer, are you interested in trying contact lenses at this time ? Yes No

Type and brand of contact lenses _____ Today's wearing time ? _____

How many hours/day ? _____ How many days/week ? _____

Please rate the following on a scale of 1-10, with 1 being POOR to 10 being EXCELLENT

	Right	Left		Right	Left		Right	Left
Lens Comfort	_____	_____	Distance Vision	_____	_____	Near Vision	_____	_____

What Solutions do you use? Cleaner _____ Disinfectant _____ Enzyme _____

SOCIAL HISTORY

Do you use nutritional supplements (vitamins etc.)? Yes No

Do you engage in regular exercise? Yes No

Do you drink alcohol ? If yes, how much/often : No Occasional 1 per day 2-3/day 4+/day

Do you smoke ? If yes, how much/often : No Occasional 1/2 pack/day 1 pack/day 1+ pack

Method of Tobacco Intake : Smoking Chewing

Do you use Illegal Drugs : Yes No

Hobbies/ Interests : _____