

Welcome to

EYES ON MAIN

Our mission is to ensure the utmost quality of life to each and every patient regarding vision and the health of their eyes. To provide each patient with outstanding service, respect, education, and a thoroughness not seen elsewhere. We appreciate your patronage and will work hard to maintain your trust.

Patient Information

Last _____
First _____ MI _____
Street _____
City _____ State _____
Zip Code _____
Home Phone _____
Work Phone _____
Patient's SSN _____
Employer (or School) _____
Occupation (or Grade) _____
Spouse/Parent/Partner _____
Spouse/Parent/Partner Work _____
Date of Birth _____ Age _____
Sex M F
Email Address _____

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
 Newspaper/Radio/TV
 Yellow Pages: Which directory? _____
 Web Page: Which Web Site? _____
 Other _____

Today's Date _____

Insurance Information

Please note that insurance does NOT cover the Contact Lens Follow-Up Evaluation.

Vision Insurance _____
Subscriber Name _____
Subscriber Ins. ID# _____
Subscriber Birth Date _____
Primary Medical Insurance _____
Subscriber Name _____
Subscriber Ins. ID# _____
Subscriber Birth Date _____
Subscriber Address: _____
Subscriber City/State/Zip: _____
Subscriber Phone: _____

Do you participate in a flex spending account?
 Yes No

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

Lifestyle Questions

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

- ..work at a computer?
- ..think you might benefit from thinner, lighter lenses?
- ..have interest in a "test drive" of the latest contact lens?
- ..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 children?
- ..have family members in need of eyecare?

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

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

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 _____
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) _____

Allergies to medications? Yes No

If so, what medications? _____

Have you had any surgeries? Yes No

Do you use cigarettes/tobacco, alcohol, or other substances? Yes No

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

- | | |
|--|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Blood/Lymph | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Cholesterol |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Digestive |
| <input type="checkbox"/> Ears/Nose/Throat | <input type="checkbox"/> Endocrine |
| <input type="checkbox"/> Eczema/Rashes | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Fevers | <input type="checkbox"/> Genitourinary |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Integumentary (Skin) |
| <input type="checkbox"/> Kidney | <input type="checkbox"/> Muscle/Bone |
| <input type="checkbox"/> Neurological | <input type="checkbox"/> Psychological |
| <input type="checkbox"/> Respiratory | <input type="checkbox"/> Sinus |
| <input type="checkbox"/> Throat Infections | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Unusual weight losses/gains | |

Patient Eye History

Date of Last Eye Exam _____
By Whom? _____

Have you ever tried contact lenses? 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

Would you prefer clear contact lenses or colored contact lenses? Clear Colored

If you wear bifocals, do the lines or head tilting bother you? Yes No

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	<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"/> _____

Please be advised if you are using insurance coverage for today's visit, this is a contract between you and your insurance company...not EYES ON MAiN. Your signature below also verifies that you have been presented a copy of EYES ON MAiN notice of privacy policy complying with HIPPA regulations.

If your insurance company has not reimbursed our office in full within 90 days, your credit card will be utilized and your insurance company will then pay you directly. (If by mistake your insurance company sends the payment check to us, we will of course sign over and forward the check directly to you.)

Please enter your credit card number and expiration date.

CC#: _____

Expiration Date: _____

Signature _____