Welcome to
Eyes on Main

Patient Information

Last ______________________________

First ____________________ MI ______

Mailing ____________________________

City/State/Zip ______________________

Cell ______________________

Other ______________________

Email ______________________________

Preferred: **Text / Call / Email**

Sex: **M F** SSN: ________________

Age: __________ DOB: ___________

Employer (or school): ____________________

Occupation (or grade): ____________________

Emergency Contact: ____________________

Phone Number: __________________

What is the major purpose of this visit?

____

Any Problems with your current glasses/contact lenses?

____

How did you choose our office?

- ☐ Referred by ______________________
- ☐ Another Doctor ____________________
- ☐ Insurance Provider List
- ☐ Saw Sign/Building
- ☐ Online
- ☐ Other: __________________________

Insurance Information

Vision Insurance: ______________________

Insurance ID#: ______________________

Subscriber Name: ______________________

Subscriber DOB: ______________________

Medical Insurance: ______________________

Insurance ID#: ______________________

Subscriber Name: ______________________

Subscriber DOB: ______________________

Subscriber Address: ____________________

City/State/Zip: ______________________

Phone: ____________________________

How will you settle any balance on your account today?

Cash / Check / Card / Care Credit

Lifestyle

Do you....(check all that apply)

- ☐ work at a computer?
- ☐ feel you might benefit from thinner, lighter, lenses?
- ☐ have interest in trying the latest contact lens?
- ☐ spend time outdoors? Approx. _____ hours/week
- ☐ have prescription sun wear?
- ☐ prefer not to wear your glasses at times?
- ☐ want information on LASIK?
- ☐ have more than 1 pair of *current* Rx eyewear?
- ☐ have hobbies ______________________

  ____

Have you ever experienced, been diagnosed or treated for any of the following? (check all that apply)

- ☐ Blurry Visio
- ☐ Eye Infections
- ☐ Lazy Eye
- ☐ Trouble Seeing at Night
- ☐ Crossed Eyed/Eye Turn
- ☐ Corneal Abrasions
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Headaches/Migraines (Frequent/Occasional)
- ☐ Double Vision
- ☐ Other:
- ☐ Eye Injury
- ☐ Floaters/Spots
- ☐ Flashes of Light
- ☐ Retinal Detachment
- ☐ Iritis/Uveitis
- ☐ Dry Eyes
- ☐ Itchiness/Grittiness
- ☐ Burning
- ☐ Uncomfortable Glasses/Contacts
- ☐ Sun Sensitivity

Medical History

Name of primary care physician: ________________
Date of last physical check-up: ________________

Current medications (Rx & over the counter, incl. eye drops, vitamins & birth control): ________________________

____

____

Allergies to medications? **Yes** **No**
If so, what medications? ____________________

____

Are you pregnant or breastfeeding? **Yes** **No**

Do you use….
- ☐ Cigarettes/Tobacco If yes, how often?__________
- ☐ Alcohol If yes, how often?__________
- ☐ Other substances If yes, how often?__________

Have you had any surgeries? **Yes** **No**

Have you ever been diagnosed or treated for the following health problems? (check all that apply)

- ☐ Allergies
- ☐ Blood/Lymph
- ☐ Cancer
- ☐ Diabetes
- ☐ Ears/Nose/Throat
- ☐ Eczema/Rashes
- ☐ Fevers
- ☐ High Blood Pressure
- ☐ Kidney
- ☐ Neurological
- ☐ Respiratory
- ☐ Throat Infections
- ☐ Unusual Weight Loss/Gain
- ☐ Arthritis
- ☐ Bronchitis
- ☐ Cholesterol
- ☐ Digestive
- ☐ Endocrine
- ☐ Fatigue
- ☐ Genitourinary
- ☐ Integumentary(skin)
- ☐ Muscle/Bone
- ☐ Psychological
- ☐ Sinus
- ☐ Thyroid
- ☐ Other:

Eye History

Date of last eye exam: ______________________
By whom? ______________________________

Have you tried contact lenses? **Yes** **No**

Do you currently wear contact lenses? **Yes** **No**
If yes, what type/brand? ____________________
Solutions used: __________________________

Are you satisfied with the vision and comfort of your current contact lenses? **Yes** **No**

Do you sleep in your contact lenses? **Yes** **No**
If yes, how many days/week? ________________

Anything else you'd like us to address? __________

____

____

Family Medical & Eye Health History

Immediate family history of any of the following: (check all the apply)

	Relationship
☐ Blindness	________________
☐ Cataracts	________________
☐ Corneal Problems	________________
☐ Glaucoma	________________
☐ Lazy Eye	________________
☐ Macular Degeneration	________________
☐ Retinal Problems	________________
☐ Diabetes	________________
☐ Heart Disease	________________
☐ High Blood Pressure	________________
☐ Other:______________	________________

Please be advised that if you are utilizing insurance coverage for today's visit, that is a contract between you and your insurance company, not Eyes on Main. Any balance outstanding longer that 90 days will be billed directly to you, by Eyes on Main. If, by mistake, we receive payment from your insurance, we will refund any amounts due to you.

Outstanding patient balances over 90 days will be collected by **Credit Associates** with associated fees and interest.

You signature below verifies that you understand Eyes on Main's financial policy and have been presented a copy of Eyes on Main's notice of privacy complying with HIPPA regulations.

Signature of Guarantor ______________________________ Date ________________

We appreciate you choosing Eyes on Main and greatly appreciate the referral of your family and friends!

OPTOMAP RETINAL EXAM

Eye on Main is concerned about retinal problems including macular degeneration, glaucoma, retina holes/detachments, and systemic diseases such as diabetes, stroke, and high blood pressure. These conditions can lead to serious health problems, including partial or complete loss of vision, and often develop without warning and progress with no symptoms.

Therefore, we would like to offer the Optomap Retinal Exam as an integral part of your comprehensive eye exam today.

In many cases, there will not be a need to dilate after the imaging. If our doctors determine that there is a need for dilation, this will be discussed during your exam.

An Optomap Retinal Exam provides:

- **An eye wellness scan**
- **An in-depth view of the retinal layers**
- **An *annual*, permanent record, which gives doctors the best comparisons for tracking and diagnosing potential eye disease**

Our doctors highly recommend the Optomap for all patients.

As insurance **does not cover** this advanced screening technology as part of your routine exam, this will be done as an enhancement to your comprehensive eye exam for an **additional fee of $35.**

______ I Accept

______ I would like more information

Sign: ____ **Date:** ____________________