

FAMILY EYEWEAR GALLERY

Welcome to Our Practice

Welcome to Family Eyewear Gallery. Thank you for choosing us for your eyecare needs. We are delighted to have you as a patient and appreciate the confidence you have placed in us. Please take a moment to complete the following information.

Dr. Mr. Mrs. Ms. Miss Male Female

First Name MI Last Name Preferred Name

Street Address City State Zip

Social Security Number Date of Birth Home Phone (incl. area code) Work Phone

Email Address Guardian Person Responsible for Account

Emergency Contact Emergency Phone

How were you referred to our office? Who were you referred by?

- Phone Book School Advertisement Patient
- Insurance Drove By Other Doctor

PRIMARY INSURANCE INFORMATION

Name of Primary Insurance Company City State Zip

M F _____
Insured's First Name MI Insured's Last Name

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

Patient's Relationship to Insured?

- Self Spouse Child Other Patient Status: Single Married Other

SECONDARY INSURANCE INFORMATION

Name of Primary Insurance Company City State Zip

M F _____
Insured's First Name MI Insured's Last Name

Patient's Relationship to Insured?

- Insured's ID Number Group Number 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 that services are rendered unless other arrangements are made in advance. All professional services and materials are charged to the patient. The undersigned will ultimately be responsible for any bills 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 made directly to Family Eyewear Gallery. I understand that I 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

HIPPA PRIVACY POLICY: I acknowledge that I have read and/or received Family Eyewear Gallery's Notice of Privacy Practices.

Signature Date

Name: _____

FAMILY EYEWEAR GALLERY

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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 Eyedrops: _____

Medicines that cause reactions or sensitivities: _____

Specific Allergies: _____

EYE HISTORY

- Glaucoma Yes No Dryness Yes No Strabismus (crossed eyes) Yes No
- Cataract Yes No Excess Tearing/Watering Yes No Blurred Vision Distance Yes No
- Macular Degeneration Yes No Eye Pain or Soreness Yes No Blurred Vision Near Yes No
- Retinal Detachment Yes No Foreign Body Sensation Yes No Distorted Vision (halos) Yes No
- Color Blindness Yes No Infection of Eye or Lid Yes No Double Vision Yes No
- Headaches Yes No Itching Yes No Floaters or Spots Yes No
- Glare/Light Sensitive Yes No Mucous Discharge Yes No Fluctuating Vision Yes No
- Tired Eyes Yes No Drooping of Lid Yes No Loss of Side Vision Yes No
- Amblyopia (lazy eyes) Yes No Redness Yes No Loss of Vision Yes No
- Burning Yes No Sandy or Gritty Feeling Yes No

GENERAL HEALTH CONDITIONS

- Fever Yes No Respiratory (asthma) Yes No Anxiety or Depression Yes No
- Weight Loss Yes No Gastrointestinal Yes No Thyroid, Diabetes Yes No
- Other Symptoms Yes No Kidney Yes No Blood/Lymph Yes No
- Ear, Nose, Throat Yes No Muscles, Bones, Joints Yes No Allergic Yes No
- Cardiovascular (high blood pressure, etc.) Yes No Skin Yes No Are you? Pregnant
- Neurological (Multiple Sclerosis) Yes No Nursing

FAMILY HISTORY

- Amblyopia Yes No Retinal Detachment Yes No High Blood Pressure Yes No
- Blindness Yes No Strabismus (eye turn) Yes No Kidney Disease Yes No
- Color blindness Yes No Arthritis Yes No Lupus Yes No
- Cataract(s) Yes No Cancer Yes No Stroke Yes No
- Glaucoma Yes No Diabetes Yes No Thyroid Disease Yes No
- Macular Degeneration Yes No Heart Disease Yes No Others Yes No

Name: _____

FAMILY EYEWEAR GALLERY

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SOCIAL HISTORY

Current Occupation _____ Years _____ Employer _____

SPECTACLE LENS HISTORY

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

Do you drive? Yes No How many miles 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? _____

Types of glasses Full-time Part-time Distance Close

Glasses Owned Single Vision Bifocals Trifocals Back-up Safety Progressive

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

Do you wear sunglasses? Yes No Are your sunglasses 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

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

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

Do you currently wear contact lenses? Yes No Since? _____

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 to 10, with 1 being POOR to 10 being EXCELLENT

Lens comfort	Right	Left	Distance Vision	Right	Left	Near Vision	Right	Left
_____	_____	_____	_____	_____	_____	_____	_____	_____
What solutions do you use?	Cleaner? _____		Disinfectant? _____			Enzyme? _____		

SOCIAL HISTORY

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

Have you ever tried to wear contact lenses? Yes No

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

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

Method of tobacco intake? Smoking Chewing

Do you use illegal drugs? Yes No

Hobbies/Interests? _____