WELCOME TO OUR OFFICE

Patient Information

Last ______________________________

First ________________MI ____________

Nickname __________________________

Street ______________________________

City ____________ State ______________

Zip Code ___________________________

Sex: M F

Home Phone _________________________

Work Phone _________________________

Cell Phone __________________________

Date of Birth ________________Age ________

Email Address: ______________________

Patient's SSN ________________________

Employer (or School) __________________

Occupation (or Grade) _________________

Marital Status (circle one below)

Married / Divorced / Single / Widowed / Separated

Spouse (or Parent's Name) ______________

Spouse (or Parent's Work) ______________

Ethnic Group: (circle one below)
Hispanic/Latino *or* Not Hispanic/Not Latino

RACE:
(Please circle one)

American Indian
Alaska Native
Asian
Black/African American
Native Hawaiian
Pacific Islander
White
Other
Unknown

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?

- ❑ Google search
- ❑ Insurance List
- ❑ Saw Sign/Building
- ❑ Newspaper/Radio/TV
- ❑ Yellow Pages: Which directory? ___________
- ❑ Other ____________________________

Insurance Information

Please present both vision and medical cards.

Vision Insurance______________________
Subscriber Name ______________________
Subscriber SSN _______________________
Subscriber Birth Date__________________

Primary Medical Insurance______________
Subscriber Name______________________
Subscriber SSN _______________________
Subscriber Birth Date__________________

Lifestyle Questions

(check the box if your answer is yes)

- ❑ Do you currently use a computer? If yes, how many hours a day? ____________
- ❑ Do you spend time outdoors fishing, boating, playing golf or other hobbies? List:____________
- ❑ Do you have an interest in a "test drive" of the latest contact lens designs?
- ❑ Do you have trouble with glare and/or reduced vision at night?
- ❑ Do you wear sunglasses?
- ❑ Do you have more than 1 pair of current Rx eyewear?
- ❑ Are you interested in discussing Laser Vision Correction as an option?
- ❑ Do you have family members in need of eyecare?

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

- ❑ Blurry Vision
- ❑ Cataracts
- ❑ Crossed eye/Eye turn
- ❑ Eye Infections
- ❑ Light Flashes
- ❑ Glaucoma
- ❑ Headaches
- ❑ Itchiness
- ❑ Macular Degeneration
- ❑ Retinal Detachment
- ❑ Tearing
- ❑ Uncomfortable glasses
- ❑ Other eye disorders____________________
- ❑ Burning
- ❑ Corneal Abrasions
- ❑ Double Vision
- ❑ Eye Injury
- ❑ Floaters/Spots
- ❑ Grittiness
- ❑ Glare
- ❑ Lazy Eye
- ❑ Dry Eyes
- ❑ Light Sensitivity
- ❑ Trouble seeing at night

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_____________________
Preferred Pharmacy_______________________________
Diabetic Doctor (if applicable)

____

CURRENT MEDICATIONS (Rx or Over the Counter)

____
____
____
____
____

Do you take a daily multivitamin/supplement? Y/ N
If so, which one?_________________________________

Allergies to medications? ❑ Yes ❑ No
If so, what medications? __________________________
____

Tobacco Use ❑ Yes ❑ No
Alcohol Use ❑ Yes ❑ No
Illicit Drug Use ❑ Yes ❑ No
Length of Tobacco Use_________________________
How much/ How often _________________________

Are you pregnant/possibly pregnant? ❑ Yes ❑ No

Have you ever been diagnosed or treated for:
(Check and explain if yes)

Allergies ❑ ________________________
Arthritis ❑ ________________________
Blood/Lymph ❑ ________________________
Bronchitis ❑ ________________________
Cancer ❑ ________________________
Cholesterol ❑ ________________________
Diabetes ❑ ________________________
Digestive ❑ ________________________
Ears/Nose/Throat ❑ ________________________
Endocrine ❑ ________________________
Eczema/Rashes ❑ ________________________
Fatigue ❑ ________________________
Fevers ❑ ________________________
Genitourinary ❑ ________________________
High Blood Pressure ❑ ________________________
Integumentary (skin) ❑ ________________________
Kidney ❑ ________________________
Muscle/Bone ❑ ________________________
Neurological ❑ ________________________
Psychological ❑ ________________________
Respiratory ❑ ________________________
Sinus ❑ ________________________
Throat Infections ❑ ________________________
Thyroid ❑ ________________________
Unusual weight loss/gain ❑ ________________________

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

What is the reason (or reasons) for your exam?

____
____
____

Family Medical/Eye History (Check all that apply)

Is there a **family history** of any of the following:

	Relationship (Mother's or Father's side)
Blindness	❑ ________________________
Cancer	❑ ________________________
Cataracts	❑ ________________________
Corneal Problems	❑ ________________________
Diabetes	❑ ________________________
Glaucoma	❑ ________________________
Heart Disease	❑ ________________________
High Blood Pressure	❑ ________________________
High Cholesterol	❑ ________________________
Kidney Disease	❑ ________________________
Lazy Eye	❑ ________________________
Macular Degeneration	❑ ________________________
Retinal Problems	❑ ________________________
Stroke	❑ ________________________

Payment Is Due When Services are Rendered

Please be advised if you are using insurance coverage for today's visit, this is a contract between you and your insurance company...not North Wake Eye Care.
If your insurance company has not reimbursed our office in full within 90 days, you will be responsible for any balance due.
In case of default, patient is liable for all late penalties and collection fees.
Patient is responsible for all returned check fees from banks and North Wake Eye Care.
I understand / accept the above statement and authorize North Wake Eye Care to provide treatment to my eyes.

Signature______________________________________