WELCOME TO OUR OFFICE

NORTHWAKE EYECARE

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 _____
$20 CREDIT FOR ALL REFERRALS! (1/Family)

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
- ❑ Burning
- ❑ Cataracts
- ❑ Corneal Abrasions
- ❑ Crossed eye/Eye turn
- ❑ Double Vision
- ❑ Eye Infections
- ❑ Eye Injury
- ❑ Light Flashes
- ❑ Floaters/Spots
- ❑ Glaucoma
- ❑ Grittiness
- ❑ Headaches
- ❑ Glare
- ❑ Itchiness
- ❑ Lazy Eye
- ❑ Macular Degeneration
- ❑ Dry Eyes
- ❑ Retinal Detachment
- ❑ Light 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_____
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_____