

# WELCOME TO OUR OFFICE

## Patient Information

Today's Date \_\_\_\_\_

Single      Married      Widowed      Divorced

Last \_\_\_\_\_ Sex: M F

First \_\_\_\_\_ MI \_\_\_\_\_

Patient's SSN \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Street \_\_\_\_\_

P.O. Box # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

Employer (or School) \_\_\_\_\_

Occupation (or Grade) \_\_\_\_\_

Email Address \_\_\_\_\_

Spouse (or Parent's Name) \_\_\_\_\_

Spouse (or Parent's Work) \_\_\_\_\_

What is the major purpose of this visit?  
\_\_\_\_\_  
\_\_\_\_\_

Any problems with your current contact lenses or glasses?  
\_\_\_\_\_  
\_\_\_\_\_

Are you planning to get new glasses today?  
 Yes    No    Only if prescription changes

## Insurance Information

***Please note that most insurance does NOT cover the Refraction or the Contact Lens Evaluation. You will be responsible for these fees at today's visit.***

Please be advised: If you are using insurance coverage for today's visit, this is a contract between you and your insurance company, not Feidler Eye Clinic.

Which vision insurance plan do you have (if any)?

Vision Service Plan (VSP)    Eye Med

Subscriber Name \_\_\_\_\_

Subscriber SSN \_\_\_\_\_

Primary Medical Insurance \_\_\_\_\_

Subscriber Name \_\_\_\_\_

Subscriber SSN \_\_\_\_\_

Subscriber Birth Date \_\_\_\_\_

Do you participate in a flex spending account?

Yes       No

How will you settle your account today?

Cash       Check       Credit Card

## 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?

- I am a previous patient of this office
- Another Doctor \_\_\_\_\_
- This office takes my insurance \_\_\_\_\_
- Saw Sign/Building       Yellow Pages
- Newspaper / Radio / (circle all that apply)
- Feidler Eye Clinic Web Page
- Other \_\_\_\_\_

## Lifestyle Questions

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

- work at a computer? If yes, please complete computer questionnaire.
- think you might benefit from thinner, lighter lenses?
- have interest in a "test drive" of the latest contact lens designs
- spend time outdoors? How much? \_\_\_\_\_ Hrs/week
- have sunglasses?    Prescription    Non-prescription
- prefer not to wear your glasses at times?
- want information on Laser Vision Correction surgery?
- have visual difficulty when driving?
- participate in sports activities?
- have more than 1 pair of current Rx eyewear?

**Have you ever experienced, been diagnosed or treated for any of the following? (check if yes)**

- 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
- Dryness
- Glare Problems
- Contact lens discomfort
- Other eye disorders \_\_\_\_\_

***The mission of Feidler Eye Clinic and Optical is to enhance your quality of life by preserving the precious gift of sight through exceptional:***

***Commitment      Value      Service      Patient Education***

The information in this confidential case history form is critical to the evaluation of your vision and health.

Patient Medical History		
Family Physician	_____	
Town	_____	
Date of Last Physical Check-up	_____	
<b>CURRENT MEDICATIONS (Rx or Over the Counter)</b>		
(List name of medications including eye drops, vitamins, & birth control pills) _____		
_____		
_____		
_____		
Allergies to medications?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
If so, what medications?	_____	
_____		
Have you had any surgeries?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
_____		
Do you use cigarettes/tobacco?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you drink alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you ever been diagnosed or treated for the following health problems?	Yes	No
Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Blood/Lymph	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Digestive	<input type="checkbox"/>	<input type="checkbox"/>
Ears/Nose/Throat	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine	<input type="checkbox"/>	<input type="checkbox"/>
Eczema/Rashes/Rosacea	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Fevers	<input type="checkbox"/>	<input type="checkbox"/>
Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Integumentary (Skin)	<input type="checkbox"/>	<input type="checkbox"/>
Kidney	<input type="checkbox"/>	<input type="checkbox"/>
Muscle/Bone	<input type="checkbox"/>	<input type="checkbox"/>
Neurological	<input type="checkbox"/>	<input type="checkbox"/>
Psychological	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>
Sinus	<input type="checkbox"/>	<input type="checkbox"/>
Throat Infections	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Unusual weight losses/gains	<input type="checkbox"/>	<input type="checkbox"/>

Patient Eye History	
Date of Last Eye Exam	_____
By Whom?	_____
Have you ever tried contact lenses?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If no, are you interested in trying contacts today?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you currently wear contact lenses?	<input type="checkbox"/> Yes <input type="checkbox"/> No
What kind?	_____
Solutions used	_____
How often do you dispose of your contacts?	<input type="checkbox"/> Daily <input type="checkbox"/> 2 weeks <input type="checkbox"/> Monthly <input type="checkbox"/> When they feel bad
Are you satisfied with the vision and comfort of your contact lenses?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If you wear bifocal glasses, does the lines or head tilting bother you?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever had any eye surgeries?	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	
Have you ever had any eye injuries?	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	

Family Medical/Eye History (Check all that apply)			
Is there a family medical history of any of the following?			
If yes, please list relationship (Mother or Father's side).			
	Yes	No	<u>Relationship</u>
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	_____
Corneal Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lazy Eye	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____

I authorize the release of any medical information necessary to process all insurance claims. I also authorize the release of payment for medical benefits directly to my physician. I am also aware that I am responsible for any charges that have not been paid, or been covered by my insurance.

Signature \_\_\_\_\_

Date \_\_\_\_\_

Physician's Signature \_\_\_\_\_

Date \_\_\_\_\_