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 <u>NOT</u> 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_____

CURRENT MEDICATIONS (Rx or Over the Counter)
(List name of medications including eye drops, vitamins, & birth control pills)_____

Allergies to medications? ❑ Yes ❑ No
If so, what medications?_____

Have you had any surgeries? ❑ Yes ❑ No

Do you use cigarettes/tobacco? ❑ Yes ❑ No

Do you drink alcohol? ❑ Yes ❑ No

Have you ever been diagnosed or treated for the following health problems?

	Yes	No
Allergies	❑	❑
Arthritis	❑	❑
Blood/Lymph	❑	❑
Bronchitis	❑	❑
Cancer	❑	❑
Cholesterol	❑	❑
Diabetes	❑	❑
Digestive	❑	❑
Ears/Nose/Throat	❑	❑
Endocrine	❑	❑
Eczema/Rashes/Rosacea	❑	❑
Fatigue	❑	❑
Fevers	❑	❑
Genitourinary	❑	❑
High Blood Pressure	❑	❑
Integumentary (Skin)	❑	❑
Kidney	❑	❑
Muscle/Bone	❑	❑
Neurological	❑	❑
Psychological	❑	❑
Respiratory	❑	❑
Sinus	❑	❑
Throat Infections	❑	❑
Thyroid	❑	❑
Unusual weight losses/gains	❑	❑

Patient Eye History

Date of Last Eye Exam_____
By Whom?_____

Have you ever tried contact lenses? ❑ Yes ❑ No
If no, are you interested in trying contacts today? ❑ Yes ❑ No
Do you currently wear contact lenses? ❑ Yes ❑ No
What kind?_____
Solutions used_____
How often do you dispose of your contacts?
❑ Daily ❑ 2 weeks ❑ Monthly ❑ When they feel bad
Are you satisfied with the vision and comfort of your contact lenses? ❑ Yes ❑ No

If you wear bifocal glasses, does the lines or head tilting bother you? ❑ Yes ❑ No

Have you ever had any eye surgeries? ❑ Yes ❑ No
_____

Have you ever had any eye injuries? ❑ Yes ❑ 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	Relationship
Blindness	❑	❑	_____
Cataracts	❑	❑	_____
Corneal Problems	❑	❑	_____
Diabetes	❑	❑	_____
Glaucoma	❑	❑	_____
Heart Disease	❑	❑	_____
Lazy Eye	❑	❑	_____
Macular Degeneration	❑	❑	_____
Retinal Problems	❑	❑	_____

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 _____