

Guardian: _____ Date: 2/12/14

Name: _____

Address: _____

City, St: _____ Zip: _____

Phone(H): _____ W: _____ C: _____

Date of Birth: _____ Sex: _____

E-Mail: _____

Occupation: _____

Notify me by: Text Phone Email Mail

Who may we thank for referring you to our office?

Friend Insurance Phone Book Other...

Emergency Contact Name and Phone: _____

Approx. Date of Last Eye Exam: _____

What is the major purpose of this visit:

- Blur at Far
- Blur at Near
- Blur at Far & Near
- Itching
- Burning
- Redness
- Eye pain
- Eye strain
- Flashes/Floaters
- Loss of vision
- Double vision
- Sandy/Gritty
- Spots or shadows
- Diabetes eye
- Medical eye
- Other...

Which Eye? Right eye Left Both eyes

How long has it bothered you?

- Started today
- 1-2 days
- 3-7 days
- 1-2 weeks
- 2-4 weeks
- 1-3 months
- 3-6 months
- Over 6 months

Severity? Mild Moderate Severe

Getting Worse?

- Getting better
- Getting worse
- About the same

Current Prescription:

Glasses: Right _____

Left _____

Contacts: Right _____

Left _____

Medical Doctor(s): _____



- Race
- American Indian or Alaska
 - Asian
 - Black or African-
 - Native Hawaiian or Other Pacific
 - Other
 - Unknown/undetermine
 - White

- Ethnicity
- Hispanic or Latino
 - Not Hispanic or Latino
 - Unknown

- Language
- English
 - Spanish
 - French
 - Japanese
 - Russian
 - Other...

- Smoking
- 1 Current everyday
 - 2 Current some day smoker
 - 3 Former smoker
 - 4 Never smoker
 - 5 Smoker, current status unknown
 - 9 Unknown if ever smoked

Please note that insurance does NOT cover the Contact Lens Fitting Evaluation Vision or Primary Insurance

Ins. Name: _____

Ins Number: _____

Relationship: _____

Insured: _____

Insured DOB: _____ Ins. Sex: M F

Co-pay: _____ Materials: Y N

Medical or Secondary Insurance

Ins. Name: _____

Ins Number: _____

Relationship: _____

Insured: _____

Insured DOB: _____ Ins. Sex: M F

Co-pay: _____ Materials: Y N

Participate in a flex spending account? Y N

Past Medical History

- | | | |
|--|---|--|
| <input type="checkbox"/> Allergy | <input type="checkbox"/> Eye Surgery | <input type="checkbox"/> Psychological |
| <input type="checkbox"/> Amblyopia | <input type="checkbox"/> Gastrointestinal | <input type="checkbox"/> Sinus |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart | <input type="checkbox"/> Other... |
| <input type="checkbox"/> Cataract | <input type="checkbox"/> High B.P. | |
| <input type="checkbox"/> Crossed Eyes | <input type="checkbox"/> Keratoconus | |
| <input type="checkbox"/> Diabetes I | <input type="checkbox"/> Kidney | |
| <input type="checkbox"/> Diabetes II | <input type="checkbox"/> Lasik | |
| <input type="checkbox"/> Droopy Lid | <input type="checkbox"/> Lazy Eye | |
| <input type="checkbox"/> Ear Problem | <input type="checkbox"/> Macular Degen. | |
| <input type="checkbox"/> Eye Infection | <input type="checkbox"/> Migraine | |
| <input type="checkbox"/> Eye Injury | <input type="checkbox"/> MS | |

Eye wear History

- | | | | |
|------------------------------------|--|-------------------------------------|---|
| <input type="checkbox"/> Glasses | <input type="checkbox"/> No-line | <input type="checkbox"/> Gas Perm | <input type="checkbox"/> Disposable |
| <input type="checkbox"/> Bifocals | <input type="checkbox"/> Soft Contacts | <input type="checkbox"/> Hard | <input type="checkbox"/> Overnight wear |
| <input type="checkbox"/> Trifocals | <input type="checkbox"/> Toric Soft | <input type="checkbox"/> Monovision | |

Mark box if yes.

- Have you tried contact lenses?
- Not satisfied with the vision comfort of your contact lenses?
- Would prefer colored contacts?
- Do the lines and head tilting bother you with bifocals?

Allergies

- None
- Sulf
- Other...
- Penicillin
- Eye drops

Lifestyle Questions

Do you...(Check box if your answer is yes)

- | | |
|--|--|
| <input type="checkbox"/> Work at a computer often? | <input type="checkbox"/> Prefer not to wear your glasses at times? |
| <input type="checkbox"/> Think you might benefit from thinner lenses? | <input type="checkbox"/> Want info. on Laser Vision Correction |
| <input type="checkbox"/> Would like to "test drive" the latest contact lenses? | <input type="checkbox"/> Have more than 1 pair of current Rx |
| <input type="checkbox"/> Spend time outdoors? | |

Social History

- | | | |
|-----------------------------------|--|---|
| <input type="checkbox"/> Computer | <input type="checkbox"/> Fishing | <input type="checkbox"/> No alcohol or drug abuse |
| <input type="checkbox"/> Reading | <input type="checkbox"/> Tennis | <input type="checkbox"/> Other... |
| <input type="checkbox"/> Student | <input type="checkbox"/> Swim | |
| <input type="checkbox"/> Music | <input type="checkbox"/> Bike | |
| <input type="checkbox"/> Skiing | <input type="checkbox"/> Drug Abuse | |
| <input type="checkbox"/> Golf | <input type="checkbox"/> Alcohol Abuse | |

Current Medicines

Amount

Current Medicines	Amount

Family History

- | | |
|---|--|
| <input type="checkbox"/> Blindness | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> High B.P. |
| <input type="checkbox"/> Crossed Eyes | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Color Blind | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> None |
| <input type="checkbox"/> Macular Degen. | <input type="checkbox"/> Other... |
| <input type="checkbox"/> Retina Disease | |
| <input type="checkbox"/> Retina Detach | |

Our office requires payment at the time of service unless we "accept assignment" on your insurance. **You are responsible if your insurance doesn't pay. Contact lens fit and follow up care is billed separately from your eye exam.** Your information is protected by our privacy policy

I have received a copy of Decker Eye Care LLC "Notice of Privacy Practices". I certify that the information given by me in applying for insurance payment is true and correct. I authorize Decker Eye Care to act as my agent in filing for insurance benefits.

Remind me of my appointment by: Text

Signature _____ Date _____

Relationship to Patient: _____