WELCOME TO OUR OFFICE

MISSION EYECARE

Today's Date:

Patient Information

Last _____
First _____MI _____
Street _____
City _____ State _____
Zip Code _____
Home Phone _____
Work Phone _____
Cell Phone _____
Email Address _____
How do you prefer to be contacted?
(Indicate #1 and #2 Choice):
Home #___Work #___Cell #___Text___Email____

Patient's SSN _____
Employer (or School) _____
Occupation (or Grade) _____
Date of Birth _____Age _____
Sex: Male Female
Ethnicity_____Language_____
Spouse (or Parent's) Name _____
Spouse (or Parent's) Cell _____

What is the major purpose of this visit?

_____

Any problems with your current contact lenses or glasses?____
_____
_____

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?
❑ Another Doctor Recommended
❑ Insurance List
❑ Saw Sign / Building
❑ Newspaper/Radio/TV/Magazine Advertisement
❑ Phone Book
❑ Online: Which Web Site? _____
❑ Other _____

The mission of our practice is to provide exceptional, comprehensive eye care, individually tailored through communication & education, utilizing the latest state-of-the-art technology to enhance our patients' quality of life. Our highly competent doctors & staff will dedicate themselves to the highest ethical standards and share their expertise through thoughtful recommendations to help our patients better understand their eye health and safeguard their precious vision for a lifetime. We are committed to an atmosphere of integrity, professionalism, genuine enthusiasm and uncompromising service.

Insurance Information

Please note that insurance may NOT cover all services in their entirety. All co-pays are due on day of service.

Vision Insurance_____
Subscriber Name_____
Subscriber SSN_____
Subscriber Birth Date_____

Primary Medical Insurance_____
Subscriber Name_____
Subscriber SSN/ID#_____
Subscriber Birth Date_____

Secondary Medical Insurance_____

Do you participate in a flex spending account (FSA)?
❑ Yes ❑ No
How will you settle your account today?
❑ Cash ❑ Check ❑ Credit Card

Lifestyle Questions

Do you …… (check box if your answer is YES.)
❑...work at a computer? How many hrs/day? _____
❑...think you might benefit from thinner, lighter lenses?
❑...have interest in a "test drive" of the latest contact lens?
❑...spend time outdoors? How many hrs/week? _____
❑...have prescription sunwear?
❑...prefer not to wear your glasses at times?
❑...want information on Laser Vision Correction surgery?
❑...have interest in a non-surgical approach to vision correction?
❑...have more than 1 pair of current Rx eyewear?
❑...have children?
❑...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 Eyes (Eye Turn)	❑ Double Vision
❑ Eye Infections/Red Eye	❑ Eye Injury
❑ Flashes of Light	❑ Floaters/Spots
❑ Glaucoma	❑ Grittiness
❑ Headaches/Eyestrain	❑ Iritis/Uveitis
❑ Itchy Eyes	❑ Lazy Eye
❑ Macular Degeneration	❑ Occasional Dryness
❑ Retinal Detachment	❑ Sunlight Sensitivity
❑ Watery Eyes	❑ Trouble Seeing at Night

❑ Uncomfortable Glasses/Contact Lenses
❑ Keratoconus / Corneal Dystrophy
❑ 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_____
Clinic Name_____
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, alcohol, or other substances? (even socially) ❑ 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	❑	❑
Fatigue	❑	❑
Fevers	❑	❑
Genitourinary	❑	❑
High Blood Pressure	❑	❑
Integumentary (Skin)	❑	❑
Kidney	❑	❑
Muscle/Bone	❑	❑
Neurological	❑	❑
Psychological	❑	❑
Respiratory	❑	❑
Sinus	❑	❑
Throat Infections	❑	❑
Thyroid	❑	❑
Unusual weight losses/gains	❑	❑

MISSION EYECARE

Patient Eye History

Date of Last Eye Exam_____
Dr or Clinic Name_____

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

Would you prefer clear contact lenses or colored contact lenses? ❑ Clear ❑ Colored

If you wear bifocals, do the lines or head tilting bother you? ❑ Yes ❑ No

Family Medical/Eye History

Is there a family medical history of any of the following:
❑ No ❑ Yes (check boxes below)

	Relationship (Mother's or Father's side)
Blindness	❑_____
Cataracts	❑_____
Corneal Problems	❑_____
Diabetes	❑_____
Glaucoma	❑_____
Heart Disease	❑_____
Lazy Eye	❑_____
Macular Degeneration	❑_____
Retinal Problems	❑_____

Please be advised: if you are using insurance coverage for today's visit, this is a contract between you and your insurance company... not Mission EyeCare. We may submit your claim on your behalf as a courtesy to you. Some services may not be covered by your insurance. If your insurance company has not reimbursed our office within 60 days, you are responsible for providing payment in full to Mission EyeCare for any outstanding balance due.

I authorize the release of any medical/personal information necessary to process this claim. I agree to pay any non-covered charges and copays as instructed by my insurance company. I also request payment of benefits to myself, or the party who accepts assignment (Mission EyeCare).
I acknowledge that I have been offered or received a copy of the privacy practices of this office. (HIPAA compliance)

Signature _____ Date_____