Welcome to . Thank you for choosing us for your eye care needs. We are delighted to have you as a patient and appreciate the confidence you placed in us. Please take a moment to complete the following information.

☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms. ☐ Male ☐ Female

First Name MI Last Name Preferred Name

Street Address City State Zip

Social Security Number Date of Birth Cell Phone - Include Area Code Day Phone

Email Address Guardian Person Responsible for Account

PRIMARY INSURANCE INFORMATION (VISION INSURANCE)

Name and Address of Primary Insurance Company City State Zip

M ☐ F ☐ Insured's First Name MI Insured's Last Name

Insured's Identification Number Group Number Insured's Date of Birth

Patient Relationship to Insured
☐ Self ☐ Spouse ☐ Child ☐ Other

Patient Status ☐ Single ☐ Married ☐ Other
☐ Full Time Student ☐ Part Time Student ☐ Employed

SECONDARY INSURANCE INFORMATION (MEDICAL INSURANCE)

Name and Address of Secondary Insurance Company City State Zip

M ☐ F ☐ Insured's First Name MI Insured's Last Name

Patient Relationship to Insured

Insured's Identification Number Group Number Insured's Date of Birth ☐ Self ☐ Spouse ☐ Child ☐ Other

Please Read:

In order to control the cost of billing, we ask that the patient's portion is paid at the time services are rendered unless other arrangements are made in advance. We would rather control billing costs than be forced to raise our fees. All professional services and materials are charged to the patient. The undersigned will ultimately be responsible for any bills incurred in this office regardless of insurance. Accounts 90 days old are subject to collection fees. There will be a service charge on all returned checks.

Payment from my insurance is to be paid directly to Excel Vision. I understand that my Vision Insurance will be billed as my primary insurance. I understand that billing any secondary insurance is my responsibility. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed.

Signature Date

Name

PATIENT INFORMATION

Race

☐ American Indian Or Alaska Native
☐ Asian
☐ Black Or African American
☐ Native Hawaiian Or Other Pacific Islander
☐ Other Race
☐ White
☐ Native American
☐ Caucasian
☐ Refuse To Specify
☐ Not Disclosed
Other Race

Ethnicity

○ Hispanic Or Latino ○ Not Hispanic Or Latino ○ Unknown

Preferred Language

○ English ○ Spanish ○ French ○ Italian ○ Russian ○ Portuguese

Height ft in cm/m ○ ft in ○ cm ○ m **Weight** ○ lbs ○ kg

Emergency Contact Emergency Phone

How were you referred to our office? _____ Do you use Facebook ☐ or Yelp ☐ ?

We send text messages and e-mails for appointment reminders. Please opt-out if this is an unwanted service

PRIMARY CARE PHYSICIAN

Primary Care Physician and Clinic Name

Address of Primary Care Physician City State Zip Phone

REFERRING PHYSICIAN

Referring Physician and Clinic Name

Address of Referring Physician City State Zip Phone

Name

PATIENT HISTORY

HEALTH HISTORY

What is the main reason for today's exam ? _____

Past Surgeries: _____ _____

Major Illnesses & Injuries: _____ _____

Medicines that cause reactions or sensitivities: _____

Specific Allergies: _____

Current Medications: _____ _____

_____ _____

Current Eye Drops: _____ _____ _____ _____

Current Health Problems: _____

EYE HISTORY

Amblyopia (Lazy Eye)	○ Yes ○ No	Glare Sensitivity	○ Yes ○ No	Blurred Vision Distance	○ Yes ○ No
Blepharitis/Eyelid Irritation	○ Yes ○ No	Headaches	○ Yes ○ No	Blurred Vision Near	○ Yes ○ No
Blindness	○ Yes ○ No	Light Sensitivity	○ Yes ○ No	Distorted Vision (halos)	○ Yes ○ No
Cataract	○ Yes ○ No	Tired Eyes	○ Yes ○ No	Double Vision	○ Yes ○ No
Color Blindness	○ Yes ○ No	Burning	○ Yes ○ No	Flashes of lights	○ Yes ○ No
Diabetic Retinopathy	○ Yes ○ No	Dryness	○ Yes ○ No	Floaters or Spots	○ Yes ○ No
Dry Eye Syndrome	○ Yes ○ No	Excess Tearing/Watering	○ Yes ○ No	Fluctuating Vision	○ Yes ○ No
Eye Injuries	○ Yes ○ No	Eyelid Swelling	○ Yes ○ No	Loss of Central Vision	○ Yes ○ No
Glaucoma	○ Yes ○ No	Eye Pain or Soreness	○ Yes ○ No	Loss of Side Vision	○ Yes ○ No
Glaucoma Suspect	○ Yes ○ No	Foreign Body Sensation	○ Yes ○ No	Loss of Vision	○ Yes ○ No
High Risk Medication	○ Yes ○ No	Infection of Eye or Lid	○ Yes ○ No	Other	○ Yes ○ No
Macular Degeneration	○ Yes ○ No	Itching	○ Yes ○ No		
PeripheralVascularDisease	○ Yes ○ No	Mucous Discharge	○ Yes ○ No		
Retinal Detachment	○ Yes ○ No	Drooping Eyelid	○ Yes ○ No		
Strabismus (Crossed Eyes)	○ Yes ○ No	Redness	○ Yes ○ No		
Other	○ Yes ○ No	Sandy or Gritty Feeling	○ Yes ○ No		

GENERAL HEALTH CONDITION

Fever/ Weight Loss	○ Yes ○ No	Respiratory (Asthma)	○ Yes ○ No	Anxiety or Depression	○ Yes ○ No
Ears,Nose,Throat	○ Yes ○ No	Gastrointestinal	○ Yes ○ No	Thyroid, Diabetes	○ Yes ○ No
Cardiovascular (high blood pressure etc.)	○ Yes ○ No	Kidney, Bladder	○ Yes ○ No	Blood/Lymph	○ Yes ○ No
		Muscles,Bones,Joints	○ Yes ○ No	Allergies	○ Yes ○ No
		Skin (rash, skin cancer)	○ Yes ○ No	Are you?	☐ Pregnant ☐ Nursing
		Neurological (Multiple Sclerosis)	○ Yes ○ No		

FAMILY HISTORY

Amblyopia (Lazy Eye)	○ Yes ○ No	Macular Degeneration	○ Yes ○ No	Heart Disease	○ Yes ○ No
Blindness	○ Yes ○ No	Retinal Detachment	○ Yes ○ No	High Blood Pressure	○ Yes ○ No
Cataract(s)	○ Yes ○ No	Strabismus (Eye Turn)	○ Yes ○ No	Kidney Disease	○ Yes ○ No
Color Blindness	○ Yes ○ No	Other Eye Conditions	○ Yes ○ No	Lupus	○ Yes ○ No
Eye Tumors	○ Yes ○ No	Arthritis	○ Yes ○ No	Stroke	○ Yes ○ No
Glaucoma	○ Yes ○ No	Cancer	○ Yes ○ No	Thyroid Disease	○ Yes ○ No
Glaucoma Suspect	○ Yes ○ No	Diabetes	○ Yes ○ No	Other Diseases	○ Yes ○ No

Name

MEDICAL HISTORY QUESTIONAIRE

SOCIAL HISTORY

Current Occupation : _____ Years _____ Employer _____

Do you drink alcohol ? If yes, how much/often : ○ No ○ Occasional ○ 1 Per Day ○ 2-3/day ○ 4+/day

Do you smoke ? If yes, how much/often : ○ No ○ Occasional ○ 1/2 pack/day ○ 1 pack/day ○ 1+ pack

Past Smoker? ○ Yes ○ No When did you quit smoking? _____ Smoking Status _____

Tobacco use counseling? ○ Yes ○ No Tobacco cessation pharmacological therapy? ○ Yes ○ No

Do you chew tobacco? ○ Yes ○ No Do you use nutritional supplements (vitamins etc.)? ○ Yes ○ No

Do you use Illegal Drugs : ○ Yes ○ No Do you engage in regular exercise? ○ Yes ○ No

SPECTACLE LENS HISTORY

Do you use a computer? ○ Yes ○ No How many hours/day? _____ Distance from Computer? _____

Do you drive? ○ Yes ○ No Daily Mileage _____ Do you have visual difficulty when driving? ○ Yes ○ No

Do you have glare problems? ○ Yes ○ No Do you have problems with night vision? ○ Yes ○ No

Do you currently wear glasses ? ○ Yes ○ No Since _____

Type of glasses ☐ FullTime ☐ PartTime ☐ Distance ☐ Close

Glasses Owned ☐ SingleVision ☐ Bifocals ☐ Trifocals ☐ Backup ☐ Safety ☐ Sports ☐ Progressive

Have you had trouble in the past with glasses? ○ Yes ○ No _____

Do you wear sunglasses? ○ Yes ○ No Are your sun glasses your current prescription ? ○ Yes ○ No

SPECIAL EYEWEAR NEEDS

☐ Computer (special prescriptions, special anti-glare tints or coatings)
☐ Occupational (mechanics, plumbers, pilots)
☐ Safety Glasses (gardening, woodworking, welding)
☐ Sports/Hobbies (racquet sports, motorcycle)

Hobbies/ Interests : _____

CONTACT LENS HISTORY

Have you ever tried to wear contact lenses? ○ Yes ○ No Reason for stopping? _____

If not a contact lens wearer, are you interested in trying contact lenses at this time ? ○ Yes ○ No

Do you currently wear contact lenses? ○ Yes ○ No Since _____

Type and brand of contact lenses _____

How many hours/day ? _____ How many days/week ? _____ Today's wearing time ? _____

What Solutions do you use? Cleaner _____ Disinfectant _____ Enzyme _____

Please rate the following on a scale of 1-10, with 1 being POOR to 10 being EXCELLENT

	Right	Left		Right	Left		Right	Left
Lens Comfort	_____	_____	Distance Vision	_____	_____	Near Vision	_____	_____