

FOCUS EYECARE CENTER

WELCOME TO OUR OFFICE

Today's Date _____

PATIENT INFORMATION

Patient Name _____

Date of Birth _____ Sex M F

Email Address (for office use only) _____

Social Security Number _____

Street Address _____

City _____ State _____ Zip _____

Home Phone _____

Daytime Phone _____

Cell Phone _____

Spouse's Name _____

Spouse's Date of Birth _____

If patient is under 18, parent's name _____

Employer _____

Occupation _____

Emergency Contact Name _____

Phone Number _____

What hobbies/ sports do you enjoy? _____

HOW DID YOU HEAR ABOUT OUR OFFICE OR WHO REFERRED YOU? _____

INSURANCE INFORMATION

Please present your insurance cards so we can make a copy.

VISION INSURANCE _____

Policyholder's Name _____

Date of Birth _____

Social Security _____

MEDICAL INSURANCE _____

Policyholder's Name _____

Date of Birth _____

Social Security _____

Id# _____

Group# _____

Assignment of Benefits

I agree to pay Focus Eyecare Center and its assigns, for any and all services rendered or expenses incurred. I understand that bills are payable in full upon the rendering of treatment, however, Focus Eyecare Center will bill any applicable insurance as a courtesy. I assign Focus Eyecare Center all benefits due me for services rendered and expenses incurred. I understand that I am financially responsible for all charges not covered by this assignment and agree to pay any remaining balance.

Signature of Patient/ or Guardian _____

Date _____

EYE STYLE

Last eye exam _____

Previous eye doctor _____

Do you wear contact lenses? No Yes

If yes, what brand? _____

If no, are you interested in trying contacts? No Yes

Do you sleep in your contacts? No Yes

What solution do you use? _____

Are you interested in trying colored contacts? No Yes

Do you wear non-prescription sunglasses with your contacts? No Yes

Do you wear glasses? No Yes

All the time Occasionally

Reading Driving

Do you wear prescription sunglasses? No Yes

Are they polarized? No Yes

Are you bothered by glare from any of the following:

Night Driving Computers

Sunshine Fluorescent Lights

What do you like most about your current glasses? _____

What do you like least about your current glasses? _____

FAMILY HISTORY

Is there a family history for any of the following: Please check all that apply and list any other family history that we may need to know about.

- Cataracts
- Glaucoma
- Macular Degeneration
- Retinal Detachment
- Diabetes
- Other _____

Relationship to patient

EYE HEALTH HISTORY

Are you currently using any prescription or non-prescription eye drops? No Yes, please list _____

Have you ever had any of the following: (please check all that apply)

- | | | |
|---|--|---|
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Crossed Eyes | <input type="checkbox"/> Droopy Eyelids |
| <input type="checkbox"/> Eye Injury | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Lazy Eye |
| <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Protruding Eyes | <input type="checkbox"/> Refractive Surgery |
| <input type="checkbox"/> Loss of Vision | <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Burning Eyes |
| <input type="checkbox"/> Double Vision | <input type="checkbox"/> Dry Eyes | <input type="checkbox"/> Eye Strain |
| <input type="checkbox"/> Floaters or Flashes | <input type="checkbox"/> Headaches | <input type="checkbox"/> Itching Eyes |
| <input type="checkbox"/> Red Eyes | <input type="checkbox"/> Watering Eyes | <input type="checkbox"/> Sandy/Gritty Feeling |

MEDICAL HEALTH HISTORY

Date of last medical exam _____

Family Physician _____

Please list medications you are currently taking

Are you allergic to any medications? No Yes, please list _____

Review of Systems

Have you ever been diagnosed or treated for any of the following: (please check all that apply)

Integumentary

- Skin Disease

Neurological

- Headaches
 Multiple Sclerosis

Endocrine

- Thyroid

Immunologic

- Cancer

Ear/Nose/Mouth/Throat

- Allergies

Lymphatic/Hematologic

- Anemia

Psychiatric

- Anxiety/Depression

Respiratory

- Asthma

Vascular/Cardiovascular

- Diabetes
 Heart Disease
 High Blood Pressure
 High Cholesterol

Gastrointestinal

- Crohn's Disease
 Reflux

Urinary

- Bladder/Kidney

Bones/Joints/Muscles

- Arthritis

Please list any other medical or vision information we should know about.
