WELCOME BACK TO

Professional Family Eyecare

Today's Date _____

Patient Information

Last _____
First _____MI_____
Street _____
City _____ State _____
Zip Code _____
Home Phone _____
Daytime Phone _____
Cell Phone _____
Patient's SSN _____
Employer (or School) _____
Occupation (or Grade) _____
Date of Birth _____Age _____
Sex M F
Email Address _____
Spouse (or Parent's Name) _____
Spouse (or Parent's Phone) _____

What is the major purpose of this visit?

_____
_____

Do you have any problems with your current contact lenses or glasses?

_____
_____

Have you experienced any of the following?

❑ Eye Injury ❑ Burning
❑ Double Vision ❑ Itchiness
❑ Flash of light ❑ Tearing
❑ Floaters/Spots
❑ Other eye disorders_____

Do you currently wear contact lenses? ❑ Yes ❑ No
How often do you replace them?_____
Solutions used_____

Do you sleep in your contact lenses? ❑ Yes ❑ No

Are you satisfied with the vision and comfort of your contact lenses? ❑ Yes ❑ No

Insurance Information

Vision Insurance_____
Subscriber Name_____
Subscriber SSN_____
Subscriber Birth Date_____

Patient Medical History

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

Have you ever been diagnosed or treated for the following health problems?	**Yes**	**No**
Allergies	❑	☑
Arthritis	❑	❑
Blood/Lymph	❑	❑
Cancer	❑	❑
Cholesterol	❑	❑
Diabetes	❑	❑
Digestive	❑	❑
Ears/Nose/Throat	❑	❑
Endocrine	❑	❑
Genitourinary	❑	❑
High Blood Pressure	❑	❑
Integumentary (Skin)	❑	❑
Kidney	❑	❑
Muscle/Bone	❑	❑
Neurological	❑	❑
Psychological	❑	❑
Respiratory	❑	❑
Thyroid	❑	❑

Patient Financial Responsibility

I hereby authorize Professional Family Eyecare to apply my vision benefits on my behalf for covered services rendered. I agree to assume responsibility of full payment pending any balance that is not covered by insurance company.
Patient or Guardian's Signature

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