Patient History Form

In order to provide you the best possible care, please complete this form and bring it to your first appointment. All information is strictly CONFIDENTIAL.

PATIENT INFORMATION

Last Name	____________	Street Address	____________
First Name	____________	Suite/Apt.	____________
Date of Birth	____________	City	____________
Daytime Phone	____________	State	____________
Mobile Phone	____________	Zip code	____________
Email	____________		

GUARDIAN INFORMATION (If patient is under 18 years of age)

Last Name	____________	Street Address	____________
First Name	____________	Suite/Apt.	____________
Date of Birth	____________	City	____________
Daytime Phone	____________	State	____________
Mobile Phone	____________	Zip code	____________
Email	____________		

VISION INSURANCE INFORMATION

Insured Name	____________	Provider Phone	____________
Date of Birth	____________	Policy/I.D. No.	____________
Provider Name	____________	Group No.	____________

HOW DID YOU HEAR ABOUT *Everything In Sight* ?

- ☐ Doctor Referral
- ☐ Friend/Family Referral

Referral Name ______________________________________

- ☐ Website
- ☐ Social Media
- ☐ Google

FINANCIAL ASSIGNMENT AGREEMENT

☐ I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

ACKNOWLEDGMENT OF HIPPA

☐ Yes, I have read or had explained to me by this office HIPPA practices and I wish to continue my care under said terms

☐ No, I have not read the this office's HIPPA but was given the opportunity and declined. I wish to continue my care under said terms

☐ The HIPPA could not be read due to the emergent nature of the care needed

Patient Signature/Guardian____ Date______________________

GENERAL MEDICAL HISTORY

Primary Care Physician's Name ___________________________ Primary Care Physician's Phone____________________

When was your last eye exam? ____

Please list any surgeries: ____

Do you have any of the following conditions?

☐ Arthritis
☐ Asthma
☐ Cancer
☐ Diabetes
☐ Gastrointestinal/ Immunological
☐ Heart Disease
☐ High Cholesterol
☐ HIV
☐ Hypertension
☐ Migraines/Headaches
☐ Multiple Sclerosis

Other: ____

Do you have any family history of the following?

☐ Blindness
☐ Diabetes
☐ Eye Turn/Lazy Eye
☐ Glaucoma
☐ Hypertension
☐ Macular Degeneration

Please list any allergies: ____

VISION HISTORY

Please check all that apply:

☐ Amblyopia (lazy eye)
☐ Blurred vision at a distance
☐ Blurred vision at near
☐ Burning
☐ Diagnosis of eye illness
☐ Double vision
☐ Drooping eyelid(s)
☐ Dryness
☐ Eye pain and/or soreness
☐ Floaters or spots
☐ Fluctuating vision
☐ Foreign body sensation
☐ Halos
☐ Infection of eye or lid
☐ Itching
☐ Loss of peripheral vision
☐ Loss of vision
☐ Mucous discharge
☐ Stopped wearing contacts
☐ Stopped wearing glasses
☐ Redness
☐ Regular headaches
☐ Sandy or gritty feeling
☐ Sensitivity to light/glare
☐ Strabismus (crossed eye)
☐ Tired eyes
☐ Watery eyes

GLASSES HISTORY

What glasses do you own?

☐ Backup pair
☐ Bifocals
☐ Trifocals
☐ Distance
☐ Progressive Lenses
☐ Reading
☐ Safety Glasses
☐ Single Vision
☐ Sports Glasses
☐ Sunglasses

Check any that apply:

☐ Allergic to nickel
☐ I do not want to wear glasses
☐ Incorrect prescription
☐ Need spare glasses
☐ Need sunglasses with UV
☐ Problems with current glasses
☐ Problems with glare
☐ Problems with night vision
☐ Other: _____________________

How many hours per day do you spend using a computer?____

CONTACT LENS HISTORY

What brand of contacts do you wear? ________________ How often do you replace them? ____________________

How old are your current contacts? __________________ What solution do you use for soaking? ________________

What is your typical wearing schedule?____

Check any that apply:

☐ I do not want to wear contacts
☐ Incorrect prescription
☐ Interested in non-surgical correction
☐ Other: ____________________________
☐ Interested in refractive laser surgery
☐ Need spare contacts
☐ Problems with current contacts