IN FOCUS EYE CENTER

WELCOME TO OUR OFFICE

Date:_____

PATIENT INFORMATION

Last Name _____
First Name _____ MI _____
Preferred Name _____
Address _____
City _____ State _____
Zip code _____ Sex: M F
DOB _____ Age _____
SSN _____

We use an automated reminder/notification system. To ensure you receive these messages, we assume that your mobile number is the preferred contact.

Mobile phone _____
Home/Other phone_____
Email _____
Occupation _____
Employer _____

What is the major purpose of today's visit?

_____
_____

Have you noticed any problems with your current glasses or contact lenses?

_____
_____

VERY IMPORTANT

Who may we thank for referring you to our office?
Name of friend or relative: _____

If not referred, how did you find out about us?

- ☐ Another doctor _____
- ☐ Insurance list
- ☐ Saw building/sign
- ☐ Advertisement
- ☐ Web Site _____
- ☐ Other _____

INSURANCE / FINANCIAL

Vision Benefits _____
Subscriber name _____
Subscriber ID#/SSN_____
Subscriber DOB _____

Primary Medical Insurance _____
Subscriber name _____
Subscriber SSN/ID _____
Subscriber DOB _____

Do you participate in a flex spending or HSA account?
☐ Yes ☐ No

We are happy to bill your insurance for you if we can. However, the remaining balance after any insurance benefits are applied will remain your responsibility. Overdue balances will be sent to collections unless you arrange payment options with us in advance. In the event that you have a credit balance, you will receive a prompt refund for all balances over $25 and a credit to your account for all others, unless requested in writing. Payments by check that are returned as Insufficient Funds will be charged $40 for processing.

"I am familiar with the above financial guidelines and the patient privacy practices for In Focus Eye Center, P.C."

Signed: _____

Date: _____

If patient is a minor, please sign above to indicate you give permission to treat the patient today and print your name here: _____

The mission of In Focus Eye Center is to provide every patient the very best in complete eye care. We accomplish this through continual education in eye care and lens technologies to remain at the forefront of our profession. The visual needs, wellness and satisfaction of each patient will always be our first priority.

The information requested in this confidential case history form is critical to the evaluation of your vision and health.

MEDICAL HISTORY

Name of family physician _____

Date of last complete check up _____

Are you pregnant/nursing now? ☐ Yes ☐ No

CURRENT MEDICATIONS (Rx and non-Rx, including drops, vitamins and birth control):

_____

_____

_____

ALLERGIES TO MEDICATIONS:

_____

_____

Have you ever been diagnosed with or treated for any of the following health problems, disorders or diseases?

- ☐ Allergies
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood/lymphatic
- ☐ Cancer
- ☐ Eczema/rashes
- ☐ Fatigue
- ☐ Sudden weight changes
- ☐ Diabetes (year diagnosed: _____)
- ☐ High blood pressure
- ☐ Muscle/bone
- ☐ Neurological
- ☐ Psychological
- ☐ Respiratory
- ☐ Sinus
- ☐ Thyroid
- ☐ Melanoma

Other _____

FAMILY HISTORY

Are any of the following conditions present in any members of your family (blood relatives only)?

- ☐ Blindness
- ☐ Diabetes
- ☐ Hypertension
- ☐ Retinal problems
- ☐ Corneal problems
- ☐ Glaucoma
- ☐ Macular degeneration
- ☐ Cataract

Other _____

_____

_____

IN FOCUS EYE CENTER

EYE HISTORY

Last eye examination _____

Do you currently wear contacts? ☐ Yes ☐ No

☐ Soft ☐ Rigid/hard

If yes, are you satisfied with them? ☐ Yes ☐ No

If no, have you ever tried them? ☐ Yes ☐ No

Have you ever been diagnosed with or treated for:

- ☐ Cataract
- ☐ Recurrent infections
- ☐ Eye surgery
- ☐ Macular degeneration
- ☐ Retinal detachment
- ☐ Corneal abrasion
- ☐ Eye injury
- ☐ Keratoconus
- ☐ Glaucoma
- ☐ Turned/crossed eye

Other _____

_____

Do you experience any of the following?

- ☐ Blurred vision
- ☐ Recurrent infections
- ☐ Flashes of light
- ☐ Frequent headaches
- ☐ Itching
- ☐ Dryness
- ☐ Trouble seeing at night
- ☐ Burning
- ☐ Double vision
- ☐ Floaters/spots
- ☐ Grittiness
- ☐ Tearing
- ☐ Light sensitivity
- ☐ General discomfort

Other _____

_____

COMPUTER USE

While on the computer, do you experience:

- ☐ Headache
- ☐ Fluctuating vision
- ☐ Dry/tired/sore eyes
- ☐ Halos around objects
- ☐ Letters run together
- ☐ Distant vision blurs after use
- ☐ Fatigue
- ☐ Burning
- ☐ Squinting
- ☐ Double vision
- ☐ Need to rest eyes
- ☐ Neck pain

Other _____

_____

LIFESTYLE

Do you -

- ☐ have prescription eye wear?
- ☐ have back-up glasses that you can rely on?
- ☐ currently use sunglasses?
- ☐ drive into the sun?
- ☐ have interest in vision correction surgery?
- ☐ have family members who may need eye care?