WELCOME TO OUR OFFICE

Accent EYE CARE

Today's Date: ____/____/20____

Name: _____ Sex: M F Age: _____ Birth Date: _____/_____/_____

Address: _____ Home Phone: _____ _____

City/State/Zip: _____ Work or Cell Phone: _____ _____

Employer (or School): _____ Spouse (or Parent's Name): _____

Occupation (or Grade): _____ Spouse (or Parent's Work): _____

Social Security #: _____/_____/_____ Email Address: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Emergency Contact: _____ Emergency Phone: _____ _____

What is the main purpose of this visit? _____

List any problems with your current eyeglasses or contact lenses: _____

VERY IMPORTANT!

Who may we thank for referring you to our office? _____

If not referred, how did you choose our office?

☐ Another Dr. ☐ Newspaper ☐ Saw Sign/Building

☐ Insurance Listing ☐ Yellow Pages ☐ Web page

☐ Other: _____

INSURANCE INFORMATION

Guarantor (financially responsible person): _____Relationship to Patient: _____

Vision Insurance: _____
Subscriber Name: _____
Subscriber SSN: _____/_____/_____
Subscriber Birth Date: _____/_____/_____

Medical Insurance: _____
Subscriber Name: _____
Subscriber SSN: _____/_____/_____
Subscriber Birth Date: _____/_____/_____

Please be advised if you are using insurance coverage for today's visit, this is a contract between you and your insurance company…not Accent Eye Care.

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

How will you settle your account today? ☐ Cash ☐ Credit Card ☐ Debit

Who is financially responsible for this account? _____

By signing below, I authorize and request my insurance company to pay directly to Accent Eye Care benefits otherwise payable to me. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. Patient's portion is expected at time of service.

Also, I signify that I agree that Accent Eye Care can and will use and disclose my health information to treat me, to obtain payment for services, and to perform healthcare operations. I also acknowledge that I received the *Notice of Privacy Practices* from Accent Eye Care.

_____

Signature Date

Name: _____ Date: ____/____/_____

LIFESTYLE QUESTIONS

Do you…(check the box if your answer is yes)

- ☐ Work at the computer?
- ☐ Think you might benefit from thinner, lighter lenses?
- ☐ Have interest in a test drive of the latest contact lens designs?
- ☐ Spend time outdoors? If so, how many hours per day:
- ☐ Have prescription sunglasses?
- ☐ Prefer not to wear your glasses at times?
- ☐ Want information on laser vision correction surgery?
- ☐ Have more than one pair of prescription glasses?
- ☐ Have children?
- ☐ Have a family member in need of eye care?

MEDICAL HISTORY

Name of Medical Doctor: _____ Last Medical Exam: _____/_____/_____

Doctor's Phone: ____ _____ Last Eye Exam: _____/_____/_____

Do you have allergies to medications? no ☐ yes If yes, explain: _____

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies):

List all major injuries, surgeries and/or hospitalizations you have had: _____

EYE HEALTH: Circle all of the following that apply to you:

Blurred Vision at Distance	Burning	Foreign Body Sensation	Light Flashes
Blurred Vision at Near	Itching	Eye Pain or Soreness	Floaters or Spots
Distorted Vision / Halos	Excess Tearing / Watering	Glare / Light Sensitivity	Tired Eyes
Dryness	Mucous Discharge	Eye Strain	
Redness	Sandy or Gritty Feeling	Night Vision Difficulty	

Are you pregnant or nursing? ☐ no ☐ yes
Do you wear glasses? ☐ no ☐ yes If yes, how old is your present pair of lenses? _____
Do you wear contact lenses? ☐ no ☐ yes If yes, how old is your present pair of lenses? _____
Type of contact lenses: ☐ Rigid ☐ Soft ☐ Extended Wear ☐ Other _____
Are they comfortable? ☐ no ☐ yes
Have you had vision surgery? ☐ no ☐ yes If yes, which? RK PRK LASIK INTACS Ortho-K Other _____

FAMILY HISTORY

Please note any family history (**parents, grandparents, siblings, children**; living or deceased) for the following conditions:

DISEASE/CONDITION	NO	YES	?	RELATIONSHIP TO YOU
Glaucoma	☐	☐	☐	_____
Macular Degeneration	☐	☐	☐	_____
Retinal Detachment/ Disease	☐	☐	☐	_____
Blindness	☐	☐	☐	_____
Cataract	☐	☐	☐	_____
Crossed Eyes	☐	☐	☐	_____
Arthritis	☐	☐	☐	_____
Cancer	☐	☐	☐	_____
Diabetes	☐	☐	☐	_____
Heart Disease	☐	☐	☐	_____
High Blood Pressure	☐	☐	☐	_____
Kidney Disease	☐	☐	☐	_____
Lupus	☐	☐	☐	_____
Thyroid Disease	☐	☐	☐	_____
Other	☐	☐	☐	_____

Name: _____ Date: ____/____/_____

SOCIAL HISTORY This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

☐ I would prefer to discuss my Social History information with my doctor.

Do you drive? ☐ no ☐ yes If yes, any visual difficulties?_____

Do you use tobacco products? ☐ no ☐ yes If yes, type,/amount/ how long:_____

Do you drink alcohol? ☐ no ☐ yes If yes, type,/amount/ how long:_____

Do you use illegal drugs? ☐ no ☐ yes If yes, type,/amount/ how long:_____

Have you ever been exposed to or infected with: ☐ Gonorrhea ☐ Hepatitis ☐HIV ☐Syphilis

REVIEW OF SYSTEMS Do you currently, or have you ever had any problems in the following areas:

	NO	YES	?
CONSTITUTIONAL			
Fever, Weight Loss/Gain	☐	☐	☐
INTEFUMENTARY(Skin)	☐	☐	☐
NEUROLOGICAL			
Headaches	☐	☐	☐
Migraines	☐	☐	☐
Seizures	☐	☐	☐
Head Injury	☐	☐	☐
Multiple Sclerosis	☐	☐	☐
Myasthenia Gravis	☐	☐	☐
EYES			
Loss of Vision	☐	☐	☐
Loss of Side Vision	☐	☐	☐
Double Vision	☐	☐	☐
Corneal Abrasion	☐	☐	☐
Cataracts	☐	☐	☐
Glaucoma	☐	☐	☐
Macular Degeneration	☐	☐	☐
Retinal Disease	☐	☐	☐
Eye Injury	☐	☐	☐
Crossed Eyes / Lazy Eye	☐	☐	☐
Color Vision Abnormality	☐	☐	☐
Drooping Eyelid	☐	☐	☐
Twitching Eyelids	☐	☐	☐
Prominent Eyes	☐	☐	☐
Sties or Chalazion	☐	☐	☐
Chronic Infection of Eye or Lid	☐	☐	☐
ENDOCRINE			
Thyroid/Other Glands	☐	☐	☐
PSYCHIATRIC	☐	☐	☐

	NO	YES	?
EARS,NOSE,MOUTH,THROAT			
Allergies	☐	☐	☐
Sinus Congestion	☐	☐	☐
Runny Nose	☐	☐	☐
Post-Nasal Drip	☐	☐	☐
Chronic Cough	☐	☐	☐
Dry Throat/Mouth	☐	☐	☐
RESPIRATORY			
Asthma	☐	☐	☐
Chronic Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
VASCULAR / CARDIOVASCULAR			
Diabetes	☐	☐	☐
Heart Pain	☐	☐	☐
High Blood Pressure	☐	☐	☐
Vascular Disease	☐	☐	☐
High Cholesterol	☐	☐	☐
Stroke	☐	☐	☐
GASTROINTESTINAL			
Diarrhea	☐	☐	☐
Constipation	☐	☐	☐
GENITOURINARY			
Genitals/Kidney/Bladder	☐	☐	☐
BONES / JOINTS / MUSCLES			
Rheumatoid Arthritis	☐	☐	☐
Joint Pain	☐	☐	☐
LYMPHATIC / HEMATOLOGIC			
Anemia	☐	☐	☐
Bleeding Problems	☐	☐	☐
ALLERGIC / IMMUNOLOGIC	☐	☐	☐

If you answered YES to any of the above or have a condition not listed, please explain and list medications:

_____

_____

_____

_____ _____

Patient's Signature Date

_____ _____

Doctor's Signature Date