Patient Information Sheet

The information in this confidential personal history will be protected according to HIPAA requirements.

Name:_____ Birth Date:_____Age:_____
Mailing Address:_____ City:_____ ZIP:_____
Home Phone: _____Cell Phone: _____
Employer:_____Email:_____

IN CASE OF EMERGENCY, NOTIFY:_____Phone: _____

INSURANCE ☐ Aetna ☐ Anthem ☐ Avesis ☐ Beacon ☐ Cigna ☐ Davis ☐EyeMed ☐ Harvard ☐ JobCorps
☐Martins Point ☐ Medicare ☐ MaineCare ☐Patient Advocate ☐ TriCare ☐ VSP ☐Other_____ ☐ **None**

If you have VSP or Tricare – Please provide Social for Primary Insured _____

Does Your Insurance cover Routine Eye Exams? ☐ Yes ☐ No
If yes, how often? ☐ Every year ☐ Every 2 years

What vision improvement(s) are you interested in? ☐ Glasses ☐ Contact Lenses ☐ Laser Correction
→ *Contact Lens Evaluation & Fittings are not always covered by insurance and are the responsibility of the patient.*

What is your main reason for coming today?
☐ Poor Distance Vision ☐ Poor Near Vision ☐ Dry Eyes ☐ Headache ☐ Computer Strain
☐ Flashes of Light and/or New Floaters ☐ Diabetes ☐ Other _____

Date of your last eye examination: _____ By Whom: _____

Do you wear glasses now? ☐ Yes ☐ No

Do you currently wear contact lenses? ☐ Yes ☐ No In the past? ☐ Yes

If Yes, what brand? _____ Replacement Every: ☐ 3 months ☐ monthly
what power? _____ ☐ 2 week ☐ 1 day

OCCUPATION: What activities are you visually struggling with? _____
_____
_____ ☐**NONE**

Primary Care Doctor: _____ Location: _____

Please list all medications *(we can copy a list if you have one)*: NONE ☐
_____
_____
_____

Drug Allergies: ☐ NONE ☐ codeine ☐ latex ☐ penicillin ☐ sulfa drugs ☐ tetracycline
☐ others _____

HEALTH HISTORY: Please check the **YES or NO** box on **ALL** items**.**

Your Medical History

General

Diabetes	☐Yes	☐No	Date of diagnosis: _____
			Last A1C (blood test):_____
			Last sugar reading: _____
High Blood Pressure	☐Yes	☐No	
Heart Problems	☐Yes	☐No	Height _____
Asthma/Bronchitis	☐Yes	☐No	
Pregnant/ Lactating	☐Yes	☐No	Weight_____
Thyroid Disease	☐Yes	☐No	
High Cholesterol	☐Yes	☐No	
Arthritis	☐Yes	☐No	
Cancer	☐Yes	☐No	→Type:_____

Ocular

Glaucoma	☐Yes	☐No
Lazy Eye	☐Yes	☐No
Cataracts	☐Yes	☐No
Dry Eye	☐Yes	☐No
Eye Infection	☐Yes	☐No
Retinal Problems	☐Yes	☐No
Eye Injury	☐Yes	☐No
what: _____		
Eye Surgery	☐Yes	☐No
what: _____		
by whom: _____		

Other medical conditions?
Please List:_____
_____
_____

Do you drink? ☐Yes ☐No
amount:_____

Do you smoke now? ☐Yes ☐ No
amount: ____PPD

History of smoking? ☐Yes ☐No

Family History parents or siblings

General	Yes	No	
Diabetes	☐	☐	_____
Heart problem	☐	☐	_____
Thyroid Disease	☐	☐	_____
Blood pressure	☐	☐	_____

Other: _____
_____
_____

Ocular

Lazy eye	☐	☐	_____
Retinal problems	☐	☐	_____
Glaucoma	☐	☐	_____
Blindness	☐	☐	_____
Cataracts	☐	☐	_____
Macular Degeneration	☐	☐	_____

Other eye condition: _____
_____

PAYMENT TERMS: Office policy calls for payment at the time of service. We accept cash, check, debit, and credit card. You are responsible for fees not covered by your insurance. Insurance processing can take up to 12 months, before you receive a bill from our office.

I have read and agree to the Payment Terms and the Notice of Privacy Practices.

Signed_____ **Date**_____

VERY IMPORTANT! NEW PATIENTS:
HOW DID YOU CHOOSE OUR OFFICE?

☐ Radio AD ☐ Saw Sign ☐ Phone Book ☐ LensCrafters ☐ Facebook
☐ Insurance Website ☐ Internet Search ☐ Primary Care Doctor

Name of friend or relative_____