Patient Demographics

Patient Name ______________________________ Today's Date________________
Last
______________________________ Date of Birth ____________________
First

Address ____________________________________ **Age** ________ **Gender: M / F**

City __________________________ State________ **SSN#** ___***___-___**___-________

Zip ___________

Occupation ____________________

Phone ____________________________________ **Employer** ______________________

How did you hear about us?

Email _______________________________________
____

Would you like reminders via TEXT & EMAIL? **YES/NO**
____

What's your reason for today's visit?

____

When was your last eye exam? ____

Do you wear glasses? **YES / NO**

How often do you wear them? **All the time/Occasionally/Reading/Computer/Driving/TV/Never**

Do you wear contact lenses? **YES/ NO**

Type: _______________________ Manufacturer: __________________

Replacement Schedule:_____________ Hours Per Day: ________________

Do you have any problems/concerns in regards to your contact lenses? Please list below:

____

How would you like to pay for today's visit?

- ☐ Insurance (Please fill out insurance form)
- ☐ Visa/MC/Amex/Discover
- ☐ Check
- ☐ Cash
- ☐ Care Credit Financing
  ***ask optician for more information.**

Insurance Information

Insurance Plan/Program Name ______________________________

ID# ____

Group Account # ____

Information on Insured (Primary Plan Holder), if different from patient.

Name ________________________ Birthdate _________________

Address ___________________ Employer ___________________

__________________________ Relationship ________________

Signature On File

I certify that the information given by me in applying for insurance payment is true and correct. I authorized my doctor to act as my agent in helping me obtain payment of my insurance benefits and I authorized payment directly to Eyes All Over on my behalf.

**Because insurance company reserve the right to deny coverage,

after a claim has been filed, coverage can not be guaranteed. I agree

to be responsible for all charges not covered by my insurance.

____ ____________________

Signature Date

Eye Health History

**Please mark all that pertain to you.

- ☐ Any difficulty seeing without eyewear
- ☐ Blurry vision with current eye wear
- ☐ Burning or dryness
- ☐ Double vision
- ☐ Floaters, flashes or haloes
- ☐ Headaches
- ☐ Itching
- ☐ Redness
- ☐ Strain while reading
- ☐ Strain while using computer
- ☐ Unusual tearing
- ☐ Other ______________________
- ☐ None of the above
- ☐ Past history of eye infection
- ☐ Past history of eye injury

Personal Medical History

**Please circle all that pertain to you.

- Diabetes. If yes, circle what type **1 / 2**
- High blood pressure, arthritis, thyroid
- Chronic fever, fatigue, weight gain/ loss, epilepsy, anemia
- Ear/nose/throat: hearing loss, sinus or throat trouble
- Heart Problems/Diseases, chest pain, irregular heart beat
- Respiratory, shortness of breath, asthma, emphysema, TB
- Gastrointestinal, heartburn, abdominal pain, diarrhea, ulcers
- Urinary pain/discomfort, blood in urine
- Skin rashes, excessive dryness
- Muscle aches, joint pain, swollen joints
- Psychiatric, depression, anxiety
- Neurologic, numbness, weakness, headaches, paralysis
- HIV / AIDS
- Cancer / Leukemia
- Other ________________________

____

Family Health History

**Please name relation of person that anything below pertain to.

Diabetes ___________________________

High Blood Pressure _________________

Glaucoma__________________________

Macular Degeneration________________

Social History

Are you pregnant? Yes or No
How many kids do you have? _______

Tobacco Use? Yes or No
For how long? ___________________

Alcohol Use? Yes or No

How often? ______________________

Caffeine Use? Yes or No
How much a day? ________________

Please note anything else you'd like us to know about your health

____
____
____
____
____

Medications

____
____
____
____

Drug Allergies

____
____
____
____

Health Insurance Portability and Accountability Act (HIPAA)

Acting in compliance with federal privacy laws, I understand that Eyes All Over may use and discuss necessary personal demographic and health information with my consent and knowledge for the following reasons:

1. Processing health care insurance claims.
2. Releasing my eyewear Rxs to eyewear providers.
3. Necessary referral to specialists and consultation with other health care providers.
4. Future exam reminders.

__________________________ __________________________
Signature Date

Emergency Contact Information

First Name ______________ Last Name ______________ Gender: **M / F**
Phone ________________

Address ________________________ Relationship ____________________

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