PATIENT INTAKE INFORMATION Appt Date:_____ Appt Time: _____

First and Last Name	Preferred Name:	Gender:	DOB:
Home Phone #	Home Address		
Cell Phone #			
Email Address	Employer		
SSN (if ins. requires)	Occupation		

RESPONSIBLE PARTY (if patient is a minor)

Parent/Guardian Full Name	Relationship to Patient
Date of Birth	Primary Phone #
Address	Email Address

WHO CAN WE THANK FOR REFERRING YOU TO OUR OFFICE?

PRIMARY CARE INFORMATION

Physician Name	Phone #

☐ **By checking this box, I agree to have my records or diagnosis information shared with my physician.**

PHARMACY INFORMATION

Pharmacy Name	Address
Phone #	

STATEMENT OF FINANCIAL RESPONSIBILITY

FOR CLINIC OFFICE USE ONLY:
Today's Copayment(s): Routine $_____ Refraction $_____ Medical $_____ Retinal Screening $_____ (if applicable) Contact Fit $_____ (if applicable)

Final charges will be determined once your exam services are completed, and any material purchases have been decided upon

Please indicate your preferred payment method for today's date of service: Cash: _____Check: _____ HSA/FSA Card: _____ Debit/Credit: _____

For my eyecare provider to service my account, or to collect any amounts I may owe, I agree that I may be contacted at any number or address I have provided above or during a previous encounter. I understand that my eye exam and any optional contact lens fitting copayments are due today, and glasses or contact lenses may not be dispensed if any remaining copayments/balances are unpaid. I also understand that fees for services are non-refundable and non-negotiable, and any prescription information, for glasses or contact lenses, will have a valid expiration date indicated per federal law. I furthermore agree to pay any collection expenses incurred to collect any amount I may owe due to non-payment. I understand that I am solely responsible for the cost of all non-covered items, as outlined in detail on my receipt which includes: the specific date of service, description of each procedure/service, and the amount I am responsible for paying out-of-pocket; I certify that I have been informed of all items and cost. I authorize the release of my information for my eyecare provider to file all insurance claims if they are a participating provider for my plan. However, there is no guarantee of benefit information and/or coverage and if my insurance denies payment for any claims submitted, I will be responsible for full payment and can contact my insurance company directly should there be a dispute. My eyecare provider can also supply me with an itemized statement which I may submit to my insurance carrier, should I need to submit for reimbursement. I understand that any follow-up appointments related to a contact lens evaluation are included for three months after the initial fitting and should there be any follow-up appointments required after the three months have passed, I am responsible to pay the professional service fee. Additionally, I know that any optional testing that I have verbally agreed to pay for, is my responsibility to do as such on the date of service. Should I receive a medical examination, I understand that my major medical insurance will be billed, and I will be responsible for any deductibles, coinsurance or copayments that may be due.

- **I have read and understand the Statement of Financial Responsibility**

Signature of Patient (or Parent/Guardian) _____ Date _____

OCULAR HISTORY:

Purpose of today's visit (select all that apply):

- ❑ Annual Visit
- ❑ Blurry Vision
- ❑ Double vision
- ❑ Dryness
- ❑ Night vision difficulties
- ❑ Flash of light
- ❑ Floaters/spots in vision
- ❑ Grittiness
- ❑ Update contact lenses
- ❑ Other:_____
- ❑ Headaches
- ❑ Infection
- ❑ Itchiness
- ❑ Eye pain
- ❑ Tearing
- ❑ Burning

_____

_____

When was your last eye exam?_____

Do you wear contact lenses? Y N

Have YOU been diagnosed with the following?

- ❑ Cataracts
- ❑ Corneal abrasion
- ❑ Dry Eye
- ❑ Eye turn
- ❑ Glaucoma
- ❑ Injury
- ❑ Other eye diseases:_____
- ❑ Iritis/uveitis
- ❑ Lazy Eye
- ❑ Macular Degeneration
- ❑ Retinal defect/hole/tear
- ❑ Retinal detachment

Have you had any eye surgeries? Y N

If yes, please explain: _____

_____

_____

Has anyone in your FAMILY been diagnosed with the following?

- ❑ Cataracts
- ❑ Eye turn
- ❑ Glaucoma
- ❑ Iritis/uveitis
- ❑ Other eye diseases:_____
- ❑ Lazy Eye
- ❑ Macular Degeneration
- ❑ Retinal detachment

Visual Needs Assessment:

Hours of computer usage per day:_____

Hours of outdoor activity per day:_____

Hobbies:_____

Occupation:_____

How many hours do you read before you experience fatigue?_____

MEDICAL HISTORY:

Medications – Dosage – Including OTC:_____

_____

_____

_____

_____

_____

_____

Allergies: _____

List any prior surgeries and dates if known:_____

_____

_____

Are you pregnant or nursing? Y N

Do you use cigarettes? Y N If so, how often?

_____

Do you drink alcohol? Y N If so, how often?

_____

Have you ever been diagnosed or treated for any of the following health problems?(If yes include diagnosis; otherwise, circle N for No and F for family history)

Allergies	Y_____	N	F
Arthritis	Y_____	N	F
Blood/Lymph	Y_____	N	F
Cancer	Y_____	N	F
Cholesterol	Y_____	N	F
Diabetes	Y, Type_____	N	F
Digestive/Gastric	Y_____	N	F
Ears/Nose/Throat	Y_____	N	F
Endocrine	Y_____	N	F
Fatigue	Y_____	N	F
Fevers	Y_____	N	F
Heart Disease	Y_____	N	F
High Blood Pressure	Y_____	N	F
Immune	Y_____	N	F
Integumentary (Skin disease)	Y_____	N	F
Kidney	Y_____	N	F
Muscle or Bone	Y_____	N	F
Neurological/Headaches	Y_____	N	F
Psychological	Y_____	N	F
Respiratory	Y_____	N	F
Sinus	Y_____	N	F
Stroke/Seizures	Y_____	N	F
Throat Infections	Y_____	N	F
Thyroid	Y_____	N	F
Unusual Weight Loss/Gain	Y_____	N	F