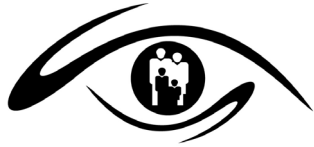


WELCOME TO



Professional Family Eyecare

Today's Date _____

Patient Information

Last _____
First _____ MI _____
Street _____
City _____ State _____
Zip Code _____
Home Phone _____
Work Phone _____
Cell Phone _____
Patient's SSN _____
Employer (or School) _____
Occupation (or Grade) _____
Date of Birth _____ Age _____
Sex M F
Email Address _____
Spouse (or Parent's Name) _____
Spouse (or Parent's Phone) _____

What is the major purpose of this visit?

Do you have any problems with your current contact lenses or glasses?

Whom may we thank for referring you to our office?

If not referred, how did you choose our office?

- Another Dr. _____
 Insurance List
 Saw Sign/Building
 Newspaper/Radio/TV: Which one? _____
 Yellow Pages: Which directory? _____
 Web Page: Which Web Site? _____
 Other _____

Insurance Information

Please note that most insurance does NOT cover the Contact Lens Medical Management.

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

Primary Medical Insurance _____
Subscriber Name _____
Subscriber SSN _____
Subscriber Birth Date _____

Do you participate in a flex spending account?
 Yes No

Lifestyle Questions

Do you.....(check box if your answer is yes)

- ..work at a computer?
 ..think you might benefit from thinner, lighter lenses?
 ..have interest in a "test drive" of the latest contact lens designs?
 ..spend time outdoors? How much? ___Hrs/week
 ..participate in sports? Which ones? _____
 ..have prescription sunwear?
 ..prefer not to wear your glasses at times?
 ..have more than 1 pair of current eyewear?
 ..wear bifocals? Do lines or head-tilting bother you?
 ..want information on Laser Vision Correction surgery?
 ..have children?
 ..have family members in need of eyecare?

Have you ever experienced, been diagnosed or treated for any of the following?

- | | |
|--|--|
| <input type="checkbox"/> Blurry Vision | <input type="checkbox"/> Burning |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Corneal Abrasions |
| <input type="checkbox"/> Crossed eye/Eye turn | <input type="checkbox"/> Double Vision |
| <input type="checkbox"/> Eye Infections | <input type="checkbox"/> Eye Injury |
| <input type="checkbox"/> Flash of light | <input type="checkbox"/> Floaters/Spots |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Grittiness |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Iritis/Uveitis |
| <input type="checkbox"/> Itchiness | <input type="checkbox"/> Lazy Eye |
| <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Occasional dryness |
| <input type="checkbox"/> Retinal Detachment | <input type="checkbox"/> Sunlight Sensitivity |
| <input type="checkbox"/> Tearing | <input type="checkbox"/> Trouble seeing at night |
| <input type="checkbox"/> Uncomfortable glasses | |
| <input type="checkbox"/> Other eye disorders _____ | |

If you checked any items above, please provide details

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

Patient Medical History	
Name of Family Physician _____ Town _____ Date of Last Physical Check-up _____	
CURRENT MEDICATIONS - Rx and Over the Counter (List name of medications including eye drops, vitamins, & birth control pills) _____ _____	
Are you allergic to any medications? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, what medications? _____	
Have you had any surgeries? <input type="checkbox"/> Yes <input type="checkbox"/> No Please Describe _____	
Do you use: cigarettes/tobacco <input type="checkbox"/> Yes <input type="checkbox"/> No alcohol <input type="checkbox"/> Yes <input type="checkbox"/> No other substances? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you ever been diagnosed or treated for the following health problems?	
	Yes No
Allergies	<input type="checkbox"/> <input type="checkbox"/>
Arthritis	<input type="checkbox"/> <input type="checkbox"/>
Blood/Lymph	<input type="checkbox"/> <input type="checkbox"/>
Bronchitis	<input type="checkbox"/> <input type="checkbox"/>
Cancer	<input type="checkbox"/> <input type="checkbox"/>
Cholesterol	<input type="checkbox"/> <input type="checkbox"/>
Diabetes	<input type="checkbox"/> <input type="checkbox"/>
Digestive	<input type="checkbox"/> <input type="checkbox"/>
Ears/Nose/Throat	<input type="checkbox"/> <input type="checkbox"/>
Endocrine	<input type="checkbox"/> <input type="checkbox"/>
Eczema/Rashes	<input type="checkbox"/> <input type="checkbox"/>
Fatigue	<input type="checkbox"/> <input type="checkbox"/>
Fevers	<input type="checkbox"/> <input type="checkbox"/>
Genitourinary	<input type="checkbox"/> <input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/> <input type="checkbox"/>
Integumentary (Skin)	<input type="checkbox"/> <input type="checkbox"/>
Kidney	<input type="checkbox"/> <input type="checkbox"/>
Muscle/Bone	<input type="checkbox"/> <input type="checkbox"/>
Neurological	<input type="checkbox"/> <input type="checkbox"/>
Psychological	<input type="checkbox"/> <input type="checkbox"/>
Respiratory	<input type="checkbox"/> <input type="checkbox"/>
Sinus	<input type="checkbox"/> <input type="checkbox"/>
Throat Infections	<input type="checkbox"/> <input type="checkbox"/>
Thyroid	<input type="checkbox"/> <input type="checkbox"/>
Unusual weight losses/gains	<input type="checkbox"/> <input type="checkbox"/>

Patient Eye History	
Date of Last Eye Exam _____ By Whom? _____	
Have you ever tried contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you currently wear contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No What kind? _____ Solutions used _____	
Do you sleep in your contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you satisfied with the vision and comfort of your contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Would you prefer clear contact lenses or colored contact lenses? <input type="checkbox"/> Clear <input type="checkbox"/> Colored	
Family Medical/Eye History (Check all that apply)	
Is there a family medical history of any of the following:	
	Relationship (Mother's or Father's side)
Blindness	<input type="checkbox"/> _____
Cataracts	<input type="checkbox"/> _____
Corneal Problems	<input type="checkbox"/> _____
Diabetes	<input type="checkbox"/> _____
Glaucoma	<input type="checkbox"/> _____
Heart Disease	<input type="checkbox"/> _____
Lazy Eye	<input type="checkbox"/> _____
Macular Degeneration	<input type="checkbox"/> _____
Retinal Problems	<input type="checkbox"/> _____

Our Mission Statement
Professional Family Eyecare is dedicated to excellence by providing complete vision care for the entire family. We are committed to performing state-of-the-art eye health evaluations by using the latest technology and educating our patients so that they thoroughly understand their vision wellness. We provide quality eyewear and the latest in contact lens design with friendly personal service. Our highest priority is to enhance our patient's quality of life by improving and protecting their precious gift of sight.

HIPPA Compliance Acknowledgement of Receipt of Privacy Notice	
Professional Family Eyecare respects the privacy of your medical records and will do all that we can to secure and protect that privacy.	
I have reviewed or received a copy of the Notice of Privacy Practice from Professional Family Eyecare. I authorize Professional Family Eyecare to use my information to submit my vision benefit claim.	
Signed _____	Date _____