Guardian: ______

Name: ______

Address: ______

City, St: ______ **Zip:** ______

Phone(H): ______ W: ______ C: ______

Date of Birth: ______ **Sex:** ______

Social Security #: ______

E-Mail: ______

Profession/Employment: ______

Notify me by: ☐ Text ☐ Phone ☐ Email ☐ Mail

Who may we thank for referring you to our office?

☐ Friend ☐ Insurance ☐ Phone Book ☐ Other…

Emergency Contact Name and Phone:

Approx. Date of Last Eye Exam:

What is the major purpose of this visit:

☐ Blur at Far
☐ Blur at Near
☐ Blur at Far & Near
☐ Itching
☐ Burning
☐ Redness
☐ Eye pain
☐ Eye strain
☐ Flashes/Floaters
☐ Loss of vision
☐ Double vision
☐ Sandy/Gritty
☐ Spots or shadows
☐ Diabetes eye check
☐ Medical eye check
☐ Other…

Specify below:

______

______

Which Eye? ☐ Right eye ☐ Left eye ☐ Both eyes

How long has it bothered you?

☐ Started today ☐ 1-2 weeks ☐ 3-6 months
☐ 1-2 days ☐ 2-4 weeks ☐ Over 6 months
☐ 3-7 days ☐ 1-3 months

Severity? ☐ Mild ☐ Moderate ☐ Severe

Getting Worse?

☐ Getting better ☐ Getting worse ☐ About the same

Current Prescription:

Glasses: Right

Left

Contacts: Right

Left

Medical Doctor(s):

(Name/Address/Phone) ______

TOTAL EYECARE

Race
◯ American Indian or Alaska Native
◯ Asian
◯ Black or African-American
◯ Native Hawaiian or Other Pacific Islander
◯ Other Race
◯ Unknown/undetermined
◯ White

Ethnicity
◯ Hispanic or Latino ◯ Unknown
◯ Not Hispanic or Latino

Language
☐ English ☐ French ☐ Russian ☐ Hungariar
☐ Spanish ☐ Japanese ☐ Portuguese ☐ Polish

Smoking
☐ 1 Current everyday smoker
☐ 2 Current some day smoker
☐ 3 Former smoker
☐ 4 Never smoker
☐ 5 Smoker, current status unknown
☐ 9 Unknown if ever smoked

Height: ______ **Weight:** ______

Please note that insurance does NOT cover the Contact Lens Fitting Evaluation

Vision or Primary Insurance

Ins. Name: ______

Ins Number: ______

Relationship: ______

Insured: ______

Insured SSN: ______

Insured DOB: ______ **Ins. Sex:** ◯ M ◯ F

Co-pay: ______ **Materials:** ◯ Y ◯ N

Medical or Secondary Insurance

Ins. Name: ______

Ins Number: ______

Relationship: ______

Insured: ______

Insured SSN: ______

Insured DOB: ______ **Ins. Sex:** ◯ M ◯ F

Co-pay: ______ **Materials:** ◯ Y ◯ N

Participate in a flex spending account? ☐ Y ☐ N

Medical History:

- ☐ Allergy
- ☐ Amblyopia
- ☐ Asthma
- ☐ Cataract
- ☐ Crossed Eyes
- ☐ Diabetes II
- ☐ Droopy Lid
- ☐ Ear Problem
- ☐ Eye Infection
- ☐ Eye Injury
- ☐ Gastrointestinal
- ☐ Glaucoma
- ☐ High B.P.
- ☐ Keratoconus
- ☐ Kidney
- ☐ Lazy Eye
- ☐ Macular Degen.
- ☐ Migraine
- ☐ MS
- ☐ Psychological
- ☐ Sinus
- ☐ Thyroid
- ☐ Other…

Specify below:

____

____

Preferred Pharmacy: ☐

Eye wear History

- ☐ Glasses
- ☐ Bifocals
- ☐ Trifocals
- ☐ No- line
- ☐ Soft Contacts
- ☐ Toric Soft
- ☐ Gas Perm
- ☐ Hard
- ☐ Monovision
- ☐ Disposable
- ☐ Overnight wear

Mark box if yes.

- ☐ Have you tried contact lenses?
- ☐ Not satisfied with the vision comfort of your contact lenses?
- ☐ Would prefer colored contacts?
- ☐ Do the lines and head tilting bother you with bifocals?

Allergies

- ☐ None
- ☐ Penicillin
- ☐ Sulfa
- ☐ Eye drops
- ☐ Other… *Specify below:*

____

Social History

- ☐ Computer
- ☐ Reading
- ☐ Student
- ☐ Music
- ☐ Skiing
- ☐ Golf
- ☐ Fishing
- ☐ Tennis
- ☐ Swim
- ☐ Bike
- ☐ Drug Abuse
- ☐ Alcohol Abuse
- ☐ No alcohol or drug abuse
- ☐ Other…

Current Medicines	**Amount**

Family History

- ☐ Blindness
- ☐ Cataracts
- ☐ Crossed Eyes
- ☐ Color Blind
- ☐ Diabetes
- ☐ Kidney Disease
- ☐ Macular Degen.
- ☐ Retina Disease
- ☐ Retina Detach
- ☐ Heart Disease
- ☐ High B.P.
- ☐ Thyroid
- ☐ Glaucoma
- ☐ Cancer
- ☐ None
- ☐ Other… *Specify below:*

____

Lifestyle Questions

Do you...**(Check box if your answer is YES)**

- ☐ Work at a computer often?
- ☐ Think you might benefit from thinner lenses?
- ☐ Would like to "test drive" the latest contact lenses?
- ☐ Spend time outdoors?
- ☐ Prefer not to wear your glasses at times?
- ☐ Want info. on Laser Vision Correction surgery?
- ☐ Have more than 1 pair of current Rx eyewear?

Our office requires payment at the time of service unless we "accept assignment" on your insurance. **You are responsible if your insurance doesn't pay.** We charge $2.00 every 2 weeks on balances over 60 days. **Contact lens fit and follow up care is billed separately from your eye exam.** Your information is protected by our privacy policy.
I have received a copy of Total EyeCare "Notice of Privacy Practices".

Remind me of my appointment by: ☐ Text

Signature__________________________ Date____________

Relationship to Patient: __________________________