

WELCOME TO OUR OFFICE

Today's Date _____

Patient Information

Last _____

First _____ MI _____

Street _____

City _____ State _____

Zip Code _____

Home Phone _____

Work Phone _____

Cell Phone _____

Email Address _____

How do you prefer to be contacted?

(Indicate #1 and #2 Choice):

Home # ___ Work # ___ Cell # ___ Text ___ Email ___

Patient's SSN _____

Employer (or School) _____

Occupation (or Grade) _____

Date of Birth _____ Age _____

Sex M F

Spouse (or Parent's Name) _____

Spouse (or Parent's Work) _____

What is the major purpose of this visit?

Any problems with your current contact lenses or glasses? _____

VERY IMPORTANT! NEW PATIENTS ONLY:

Who may we thank for referring you to our office?

Name of friend or relative _____

If not referred, how did you choose our office?

Another Dr.

Insurance List

Saw Sign/Building

Newspaper/Radio/TV

Yellow Pages: Which directory? _____

Web Page: Which Web Site? _____

Other _____

The mission of The Meadows Family Eye Care is to contribute to a lifetime of healthy vision, proving each patient with the highest quality vision care and consequent quality of life. We will seek continuing education to remain at the forefront of our profession and will offer the latest eye care technology, professional services, and products. The visual needs and wellness of each patient will always be our first priority. Everything we do shall communicate this.

Insurance Information

Lens Follow-Up Evaluation.

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

How will you settle your account today?

Cash

Check

Credit Card

Lifestyle Questions

..work at a computer? If yes, please complete computer questionnaire.

..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

..have prescription sunwear?

..prefer not to wear your glasses at times?

..want information on Laser Vision Correction surgery?

..have interest in a non-surgical approach to vision correction?

..have more than 1 pair of current Rx eyewear?

..have children?

..have family members in need of eyecare?

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

Blurry Vision

Burning

Cataracts

Corneal Abrasions

Crossed eye/Eye turn

Double Vision

Eye Infections

Eye Injury

Flash of light

Floaters/Spots

Glaucoma

Grittiness

Headaches

Iritis/Uveitis

Itchiness

Lazy Eye

Macular Degeneration

Occasional dryness

Retinal Detachment

Sunlight Sensitivity

Tearing

Trouble seeing at night

Uncomfortable glasses

Other eye disorders _____

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 or Over the Counter) (List name of medications including eye drops, vitamins, & birth control pills) _____ _____	
Allergies to 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 Do you use cigarettes/tobacco, alcohol, or 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 _____	
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	
If you wear bifocals, do the lines or head tilting bother you? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Family Medical/Eye History (Check all that apply)	
Is there a family medical history of any of the following: <input type="checkbox"/> No <input type="checkbox"/> Yes (Please check boxes)	
	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"/> _____

Please be advised if you are using insurance coverage for today's visit, this is a contract between you and your insurance company...not The Meadows Family Eye Care.

If your insurance company has not reimbursed our office in full within 60 (or 90) days, you are responsible for providing payment in full to The Meadows Family Eye Care.



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