PRECISION EyeCare

WELCOME TO OUR OFFICE

Today's Date _____

Patient Information

Last _____
First _____ MI _____
Street Address _____
City _____ State _____
Zip Code _____
Home Phone _____
Cell Phone _____
Work Phone _____
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 _____
Patient Marital Status Married Single Other
Email Address _____

What is the major purpose of this visit?

_____

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 Precision Eye Care is to provide you with professional, accurate and thorough eye and vision care in a friendly and caring environment. We are also committed to providing you with high quality products and services that will best meet your eye and vision care needs. Our goal is to enhance the quality of life for you, your family, and your community for many years to come. Thank you in advance for allowing us to serve you and fulfill our mission.

Please Complete Other Side↓

Insurance Information

Please note that certain insurances do NOT cover the Contact Lens Fitting and Follow-Up Evaluation.

Vision Insurance _____
Subscriber Name _____
Subscriber SSN/Member ID _____
Subscriber Birth Date _____
Subscriber Work Place _____

Primary Medical Insurance _____
Subscriber Name _____
Subscriber SSN/Member ID _____
Subscriber Birth Date _____
Subscriber Work Place _____

Do you participate in a flex spending account?
❑ Yes ❑ No
How will you settle your account today?
❑ Cash ❑ Check ❑ Credit Card

Lifestyle Questions

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

- ❑..Work at a computer? If yes, please describe what problems if any you may be having? _____
  _____
- ❑..Think you might benefit from thinner, lighter lenses?
- ❑..Spend time outdoors? How much? __Hrs/week
- ❑..Have prescription sun wear?
- ❑..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)_____

_____

_____

Are you currently pregnant or nursing? ❑ Yes ❑ No
Allergies to medications? ❑ Yes ❑ No
If so, what medications?_____

_____

Have you had any surgeries? ❑ Yes ❑ No
Do you use cigarettes/tobacco, alcohol, or other substances? ❑ Yes ❑ No
Do you have any sexually transmitted diseases (STDs)? ❑ Yes ❑ No

Have you ever been diagnosed or treated for the following health problems?	**Yes**	**No**
Allergies	❑	❑
Arthritis	❑	❑
Blood/Lymph	❑	❑
Bronchitis	❑	❑
Cancer	❑	❑
Cholesterol	❑	❑
Diabetes	❑	❑
Digestive	❑	❑
Ears/Nose/Throat	❑	❑
Endocrine	❑	❑
Eczema/Rashes	❑	❑
Fatigue	❑	❑
Fevers	❑	❑
Genitourinary	❑	❑
High Blood Pressure	❑	❑
Integumentary (Skin)	❑	❑
Kidney	❑	❑
Muscle/Bone	❑	❑
Neurological	❑	❑
Psychological	❑	❑
Respiratory	❑	❑
Sinus	❑	❑
Throat Infections	❑	❑
Thyroid	❑	❑
Unusual weight losses/gains	❑	❑

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Patient Eye History

Date of Last Eye Exam_____
By Whom?_____
Do you currently wear contact lenses? ❑ Yes ❑ No
What kind?_____
Solutions used_____
Are you satisfied with the vision and comfort of your contact lenses? ❑ Yes ❑ No
Would you prefer clear contact lenses and/or colored contact lenses? ❑ Clear ❑ Colored ❑ Both
If you wear bifocals, do the lines or head tilting bother you? ❑ Yes ❑ No
Would you like to be free from glasses and/or contacts? ❑ Yes ❑ No

Family Medical/Eye History (Check all that apply)

Is there a family medical history of any of the following:
❑ No ❑ Yes (Please check boxes)

	Relationship (Mother's or Father's side)
Blindness	❑_____
Cataracts	❑_____
Corneal Problems	❑_____
Diabetes	❑_____
Glaucoma	❑_____
Heart Disease	❑_____
Lazy Eye	❑_____
Macular Degeneration	❑_____
Retinal Problems	❑_____

I authorize the release of any information required in the course of my examination and treatment by the optometrist. I authorize the payment of medical benefits to the optometrist providing eye care to me.

I/We agree to the following policies regarding payment:

- All co-pays and/or examination fees are due at the time of service.
- At least 50% of the cost of glasses and/or contacts is due upon ordering, and the remainder is due at the pick up date.
- Pay all attorney fees, court costs, filing fees, and all collection costs if the above policies are not followed. Up to 50% of the amount owing may be assessed by any collection agency. Pay interest at the rate of one and one half percent per month or 18% per year.
- Pay the balance in full if my insurance company does not cover the entire balance of this account.
- **There are no refunds**. However, we can re-do lenses one time at no cost to you (within 60 days of exam if there is a change in Rx) and most lenses, frames and contacts have warranties. Also we ensure that you are satisfied with your disposable contact lenses before ordering. However, if we cannot meet your satisfaction with glasses, and at the doctor's discretion, a partial refund may be given (the amount paid over the wholesale cost of the glasses, as this amount cannot be recovered).

Signature_____
Date_____