WELCOME TO OUR OFFICE

INSIGHT EYECARE

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 _____
Race _____
Sex M F
Patient's Date of Birth _____
Employer (or School) _____
Occupation (or Grade) _____
Marital Status _____
Spouse (or Parent's) Name _____
Spouse (or Parent's) Work _____
Spouse (or Parent's) Date of Birth _____

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
❑ Internet Search

At Insight Eyecare, we strive to help our patients obtain exceptional vision at all stages of life by maintaining eye health and providing the latest options to enhance vision.

Insurance Information

Please note that medical insurance does NOT cover the Contact Lens Evaluation.

Primary Medical Insurance_____
Vision Insurance_____
Subscriber Name_____
Subscriber SSN_____
Subscriber Birth Date_____

Do you participate in a flex spending/Health Savings Account? _____
(Can be used towards exam and optical orders)

Lifestyle Questions

Do you……(check box if your answer is yes)
❑..work at a computer? If yes, how many hours per day___
❑..think you might benefit from thinner, lighter lenses?
❑..have interest in trying the latest contact lens designs?
❑..think you have trouble with night driving or glare?
❑..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 more than 1 pair of current Rx eyewear?
❑..have family members/children 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_____

Contact Lenses

Have you ever tried contact lenses? ❑Yes ❑ No
Do you currently wear contact lenses? ❑Yes ❑ No
What kind?_____
Are you satisfied with the vision and comfort of your contact lenses? ❑Yes ❑ No

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_____
Clinic Name _____
Clinic Phone _____

Pharmacy Name/Location_____

_____

Height and Weight (Must Have) _____

Are you currently pregnant or nursing? _____

Have you had any eye surgeries? ❑ Yes ❑ No
If yes, explain: _____

Have you ever been diagnosed or treated for the following health problems?	**Yes**	**No**
Allergies Hay Fever	❑	❑
Cardiovascular		
Cholesterol	❑	❑
High Blood Pressure	❑	❑
Heart Disease	❑	❑
Constitutional		
Fevers	❑	❑
Unusual weight losses/gains	❑	❑
Ears/Nose/Throat		
Sinus	❑	❑
Respiratory		
Asthma/COPD	❑	❑
Bronchitis	❑	❑
Gastrointestinal		
Crohn's	❑	❑
Ulcers/Reflux	❑	❑
Genitourinary		
Kidney Disease	❑	❑
Prostate/ Ovarian Cancer	❑	❑
Muscle/Bone		
Rheumatoid Arthritis	❑	❑
Muscle or Joint Pain	❑	❑
Integumentary (Skin)		
Skin Cancer	❑	❑
Rashes	❑	❑
Neurological/Psychiatric		
Headaches/Migraines	❑	❑
Depression/Anxiety	❑	❑
Stroke	❑	❑
Seizures	❑	❑
Endocrine		
Diabetes	❑	❑
Thyroid	❑	❑
Blood/Lymph		
Anemia	❑	❑
Bleeding Problems	❑	❑

Cancer (Explain) _____

Any Other Condition _____

_____

Medications

Current Medications (Rx or Over the Counter)
(List name of medications including eye drops, vitamins, & birth control pills)

_____

_____

_____

_____

_____

_____

_____

_____

Allergies to Medications? ❑ Yes ❑ No
If so, what kind? _____

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	❑_____
Cancer	❑_____
High Blood Pressure	❑_____
Strokes	❑_____

Do you use cigarettes? ❑ Yes ❑ No
Former Smoker? ❑ Yes ❑ No

Do you use tobacco? ❑ Yes ❑ No

Do you drink alcohol? ❑ Yes ❑ No

Please be advised if you are using insurance coverage for today's visit, this is a contract between you and your insurance company...not Insight Eyecare.
If your insurance company has not reimbursed our office in full within 90 days, you may be responsible for providing payment in full to Insight Eyecare.