

Welcome to Ultimate Eye Care!

Thank you for choosing us for your eye care needs. We are delighted to have you as a patient and appreciate the confidence you placed in us. If you have any questions please ask.

Title First Last MI Suffix Nickname

Street Address: City State Zip

Home Phone _____ Day Phone: _____ Cell Phone: _____

Email: _____

SSN (if using insurance): _____

Birth date: _____

Sex: Male _____ Female _____

Employer/School Name: _____

Emergency Contact: _____ Phone: _____

INSURANCE: WE WILL ASK TO SCAN A COPY OF YOUR MEDICAL CARD.

Patient's relationship to insured: Self _____ Spouse _____ Child _____ Other _____

Patient status: Single _____ Married _____ Other _____

Full time student _____ Part time student _____ Employed _____

How did you hear about us? Circle: Insurance Drive By Internet search Doctor Referred
Friend/family Whom may we thank for your referral? _____

Please read:

In order to control the cost of billing, we ask that the patient's portion is paid at the time services are rendered unless other arrangements are made in advance. We would rather control billing costs than be forced to raise our fees. All professional services and material are charged to the patient. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Accounts 90 days old are subject to collection fees. WE DO NOT ACCEPT CHECKS.

Payment from my insurance is to be paid directly to Ultimate Eye Care. I understand that my insurance will be billed but ultimately payment is my responsibility. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed.

Signature: _____ Date: _____

I have been informed of the HIPPA Privacy Policy. Initial: _____

Thank you for choosing Ultimate Eye Care

PATIENT MEDICAL HISTORY:

What is the main reason for today's exam? _____

OCULAR HISTORY:

Please circle/list any that apply. If none apply, please write "none".

- Do your eyes sting, burn, itch, or feel dry? Do they get red or water?
- Are you bothered by glare/haloes/bright light? Are your eyes tired? Do you experience headaches around your temples or forehead?
- Have you had any eye injuries or surgeries?
- Have you been diagnosed with cataracts, lazy eye, retinal problems, floaters, macular degeneration, color blindness, or glaucoma?

Eye medications: _____

Last eye exam: _____ Last Eye Doctor/Clinic: _____

FAMILY OCULAR HISTORY:

Check "none" _____ or write relation to family members with the following conditions:

Glaucoma _____ Macular Degeneration _____ Crossed/Lazy Eye _____
Retinal Detachment _____ Cataracts _____ Blindness _____ Color blindness _____

SPECTACLE LENS HISTORY:

What is your primary vision correction? Nothing Glasses Contacts _____

Have you had trouble in the past with glasses? If yes describe: _____

Would you like to find out if you are a candidate for LASIK? YES _____ NO _____

Would you like a prescription for computer glasses? _____ Do you have any problems with night vision? _____

Do you wear sunglasses? _____ Do you do yard work, woodwork, weld, or play high impact sports? _____

CONTACT LENS HISTORY:

Are you interested in a contact lens prescription today? _____

Are you interested in color contact lenses? _____

Have you ever tried to wear contacts? _____ Reason for stopping? _____

Do you have back up glasses? _____ Current contact lens brand: _____

How many hours do you wear your lenses per day? _____ Days per week? _____ Solution? _____

How often do you replace your lenses? _____ How often do you sleep in your lenses? _____

Rate the following on a scale of 1-10, with 1 being POOR to 10 EXCELLENT: Lens comfort: _____ Vision: _____

PATIENT MEDICAL HISTORY:

Primary Care Physician: _____ Phone: _____ Last visit: _____

Systemic Medications including over-the-counter and vitamins:

1. _____ 2. _____ 3. _____ 4. _____
5. _____ 6. _____ 7. _____ 8. _____
9. _____ 10. _____ 11. _____ 12. _____

Please list any major injuries, surgeries, or hospitalizations: _____

Do you have any allergies to latex or medicine? _____

Females: Are you pregnant or nursing? _____

Thank you for choosing ULTIMATE EYE CARE

FAMILY MEDICAL HISTORY: Does anyone in your family (list condition and relative) have any history of Diabetes, Hypertension, Heart Disease, Cancer (type), Arthritis, Lupus, Kidney problems, Thyroid problems, or Stroke? Others?

SOCIAL HISTORY:

Occupation: _____ Employer: _____

Hobbies: _____

Do you use tobacco? _____ smoking chewing How often? Occasional ½ pack/day 1 pack/day 1+pack

Alcohol? _____ How often? Occasional 1/day 2-3/day 4+/day _____ Illegal Drugs? _____

HAVE YOU EVER NOTICED THE FOLLOWING IN YOUR CHILD'S EYES?

(circle if applies, write "none" _____ or skip to next section if not applicable)

- Eye turn? NO IN OUT White appearance in pupil?
- Eyes frequently watering? Eyes frequently red? Swelling around the eyes?

DOES YOUR CHILD....

- Have trouble seeing distant objects? Lose their place while reading? Avoid close work?
- Hold reading material closer than normal? Have difficulty copying from the chalkboard?
- Tend to rub their eyes? Have difficulty recognizing the same word on a different page?
- Turn or tilt head to use one eye only? Make frequent reversals when reading or writing?
- Use finger to maintain place while reading? Omit or confuse small words when reading?
- Have headaches? Consistently perform below potential?

DO YOU CURRENTLY HAVE ANY OF THESE PROBLEMS? Circle any that apply below or write "none" here _____.

- **GENERAL:** fever, weight loss, weight gain, fatigue
- **EAR, NOSE, THROAT:** allergies, sinus, cough, dry mouth, throat
- **CARDIOVASCULAR:** high blood pressure, heart surgery, vascular disease
- **RESPIRATORY:** asthma, bronchitis, emphysema, chronic obstructive pulmonary disease
- **GENITAL, KIDNEY, BLADDER:** kidney stones, frequent urination, impotence
- **MUSCLES, BONES, JOINTS:** arthritis, joint pain, head or neck injury
- **SKIN:** growths, rashes, acne
- **NEUROLOGICAL:** headaches, migraines, seizures, multiple sclerosis
- **PSYCHIATRIC:** depression, anxiety, insomnia
- **ENDOCRINE:** thyroid, diabetes
- **BLOOD/LYMPH:** anemia, cholesterol, bleeding problems
- **ALLERGIC/IMMUNOLOGIC:** seasonal allergies, rheumatoid arthritis, AIDS, allergy shots, lupus
- **GASTROINTESTINAL:** diarrhea, constipation, ulcer, reflux