

Eyedentity

WELCOME TO EYEDENTITY

Patient Name: _____

Date of Birth: ____/____/____ SS# ____-____-____ Sex: M / F

Address: _____ City _____ State _____ Zip _____

Home Ph# _____ Work Ph# _____ Cell# _____

Can we contact you by email? _____

Employer: _____ Occupation: _____

Are you a full time student?: Yes___ No___

Marital Status: Single Married Divorced Widowed

Responsible Party Name: _____ D.O.B. ____/____/____

Relationship to Patient: _____ SSN# ____-____-____

Name of Vision Insurance: _____ ID# _____

Name of Health Insurance: _____

How did you hear about us?: _____

Are you a Contact Lens Wearer? Yes___ No___ What type? _____

If no, are you interested in contact lens today? Yes___ No___

How often do you replace your Contacts? _____ Enzyme? _____

What type of solution do you use? _____

What is your main complaint with your vision today? _____

Payment for services is due on the day of your visit. We file insurance for all plans for which we are a provider. If we are not a provider in some cases we can file your claim so that you may be reimbursed. You are liable for any co-payments, deductibles and any charges which may not be covered under your plan. A deposit is required for processing any material orders with the balance due on delivery.

Patient Signature: _____ Date ____/____/____

or

Responsible Party Signature: _____ Date ____/____/____

Medical History Questionnaire

Name: _____
 Birth Date: ___/___/___ Social Security#: ___/___/___
 Last Eye Doctor: _____
 Current Medical Doctor: _____

Today's Date: _____
 Last Eye Exam: ___/___
Mth Year
 Last Medical Exam: ___/___
Mth Yr.

Medical History

Do you have any allergies to medications? Yes No If yes, explain: _____

List any medications you take (including oral contraceptives, aspirin, over-the-counter medications and home remedies): _____

List all major injuries, surgeries and/or hospitalizations you have had: _____

Check any of the following that you have had: Reading Difficulty Crossed Eyes Lazy Eye Glaucoma
 Retinal Disease Cataracts Eye Injury

Are you pregnant and/ or nursing? Yes No

Do you wear glasses? Yes No If yes, how old is you present pair of glasses? _____
 How many pair of glasses do you currently use? _____

Do you wear contact lenses? Yes No If yes, how old is your present pair of contacts? _____
 Type of contact lenses? Rigid Soft Extended Wear Other Are they comfortable? Yes No

Have you had refractive surgery? Yes No

At work: Do you perform fine or close-up work? Yes No Is safety protection a concern at work? Yes No
 Are you outdoor all or part of the time? Yes No

Do you have trouble reading signs when driving at night? Yes No
 Are you bothered by the glare from: Overhead lighting? Yes No Oncoming headlights at night?
 Yes No
 A computer screen? Yes No

Are you sensitive in bright sunlight? Yes No
 What hobbies or recreational sports do you enjoy? _____

Family History

Have any of your relatives, living or deceased, had any of these conditions?

Ocular Disease/Condition	Yes	No	Not Sure	Relationship To You
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment/ Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Systemic Disease / Condition				
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

