# ALL EYES ON YOU, OPTOMETRY

# WELCOME TO OUR OFFICE

## Patient Information

Last ___________________________________________
First_______________________MI _________________
Street __________________________________________
City_________________________State _____________
Zip Code____________________Sex M F
Date of Birth______________________Age _________
School _________________________________________
Grade __________________________________________
Parent #1 Name_______________________________
Preferred Ph # __________________________________
Parent #1 Email _______________________________

Parent #2 Name _______________________________
Preferred Ph # __________________________________
Parent #2 Email _________________________________
How do you prefer to be contacted? For each parent, please check a box indicating preference:

| Parent #1 | | Parent #2 | |
|---|---|---|---|
| Phone ___ | Email ___ | Phone ___ | Email ___ |

Is there a second parental address?
________________________________________

**What is the major purpose of this visit?**

_______________________________________________
_______________________________________________

***VERY IMPORTANT! NEW PATIENTS ONLY:***
Who may we thank for referring you to our office?
Name of friend or relative or doctor:

_______________________________________________

If not referred, how did you choose our office?
❑ Insurance List
❑ Saw Sign/Building
❑ Web Page: Which site?_______________________
❑ Other _________________________________________

***The mission of All Eyes On You, Optometry is to contribute to a lifetime of healthy and efficient vision. We strive to provide each patient with incomparable vision care and thereby improve their 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. We treat our patients as our family...and we will always treat you to popcorn upon request.***

## Insurance Information

***Please note that insurance does NOT cover the Contact Lens Follow-Up Evaluation.***

Vision Insurance_________________________________
Subscriber Name_________________________________
Subscriber SSN (last 4 digits)______________________
Subscriber Birth Date_____________________________

Primary Medical Insurance_________________________
Subscriber Name_________________________________
Subscriber SSN (last 4 digits)______________________
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

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

❑..play any sports?_______________________________
❑..have sunwear?
❑..have interest in a non-surgical approach to vision correction?
❑..have more than 1 pair of current Rx eyewear?
❑..have family members in need of eyecare?

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

❑ Blurry vision
❑Lazy Eye
❑ Crossed eye/Eye turn
❑ Eye infections
❑ Loses place with reading
❑Errors with copying
❑ Headaches
❑ Itchiness
❑ Dislikes reading
❑Awkward or clumsy
❑ Behavior problems
❑ Double vision
❑ Rubs eyes
❑Eye injury
❑ Patching
❑ Reverses letters
❑ Short attention span
❑ Poor reading ability
❑ Eyes hurt or tire
❑ Hold book too close
❑ Sunlight sensitivity
❑ Carsickness
❑ Concerns with school performance
❑ Poor reading comprehension
❑ Other eye disorders
_______________________________

At what age did your child: Crawl_____________
Walk_____________Speak Clearly _____________

**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____________________________
City ____________________________________________
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? ❑ Yes ❑ No
If so, what medications?_____________________________
____________________________________________

Have you had any surgeries? ❑ Yes ❑ No

**Have you ever been diagnosed or treated for the following health problems?**

| | Yes | No |
|---|---|---|
| Allergies | ❑ | ❑ |
| Rheumatoid Arthritis | ❑ | ❑ |
| High Blood Pressure | ❑ | ❑ |
| Cholesterol | ❑ | ❑ |
| Ear/Nose/Throat | ❑ | ❑ |
| Diabetes | ❑ | ❑ |
| Thyroid | ❑ | ❑ |
| Gastrointestinal | ❑ | ❑ |
| Genitourinary | ❑ | ❑ |
| Eczema/Rashes | ❑ | ❑ |
| Neurological | ❑ | ❑ |
| Psychiatric | ❑ | ❑ |
| Asthma | ❑ | ❑ |
| Cancer: | ❑ | ❑ |

Type _______________

Use the space below for any other health/ medical information you would like to note:

**Any previous testing, therapy or remedial work?**

_________________________________________________
_________________________________________________

## Patient Eye History

Date of Last Eye Exam_____________________________
By Whom?______________________________________

Do you currently wear glasses? ❑ Yes ❑ No

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 to dispose of your contact lenses daily?
❑ 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)

| | | Please specify relationship |
|---|---|---|
| Glaucoma | ❑ | ________________ |
| Cataracts | ❑ | ________________ |
| Macular Degeneration | ❑ | ________________ |
| High Blook Pressure | ❑ | ________________ |
| Diabetes | ❑ | ________________ |
| Corneal Problems | ❑ | ________________ |
| Retinal Problems | ❑ | ________________ |
| Lazy Eye | ❑ | ________________ |

Please be advised if you are using insurance coverage for today's visit, this is a contract between you and your insurance company...not All Eyes On You, Optometry.

Co-payments and deductibles are due at the time services are rendered. I authorize payment of medical benefits directly to All Eyes On You, Optometry.

Parent or Guardian Signature Date

Parent or Guardian Signature Date

Parent or Guardian Signature Date

Parent or Guardian Signature Date