



Welcome to our office
The mission of 20/20 Eyecare Centers
is to provide our patients with the highest quality eye care
and materials in a friendly and professional atmosphere. In
everything we do we shall strive to communicate this.

Today's Date:

Patient Information

Last
First MI
Street or PO
City
State Zip Code
Primary phone
Secondary phone
Optional phone
Date of birth
Patient's SSN
Gender: Male or Female (circle one)
Email address:

How do you prefer we contact you: call / email / text

Employer (or school)
Occupation (or grade)
Spouse or parent name
Spouse or parent's work

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 or building
Newspaper/radio/TV
Yellow Pages: which directory?
Web Page: which site?
Other

Insurance Information

Please be advised: if you are using insurance coverage for
today's visit, this is a contract between you and your
insurance company, not 20/20 Eyecare Centers.

Also, insurance typically does NOT cover the Contact Lens
evaluation (upgrade to contact exam) or any fitting fees.

Vision insurance
Subscriber name
Subscriber ID
Subscriber birth date
Primary Medical Insurance
Subscriber name
Subscriber ID
Subscriber birth date

Do you participate in a flex spending account? YES NO

Our policy: Payment is due on date of service unless it is
covered by insurance - then we will bill them for you.

How will you settle your account today? (If insurance
coverage - any amount over insurance benefits, copays, etc.)

Circle one: CASH CHECK CREDIT CARD

Lifestyle Questions

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

- ..think you might benefit from thinner, lighter lenses?
..have interest in a "test drive" of the latest contact
lens designs?
..spend time outdoors? How much? hrs/week
..work at a computer? If yes, please complete
computer questionnaire. (ask for at front desk if not
attached)
..have prescription sunwear?
..prefer not to wear your glasses at times?
..want information on Laser Vision Correction surgery?
..have more than one pair of current Rx eyewear?
..have children in the home?
..have family members in need of Eyecare?
..have an interest in reserving next years exam
time & date today? We can schedule that for you
today!

Don't forget to reserve your next appt at the end of your
exam today! We will send you a postcard reminder a few
weeks before that appt. to remind you of the date & time
whenever an appt. is pre-appointed (scheduled in advance).

Continued on reverse side...

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) _____

Do you have any allergies to medications? YES NO

If so, what medications? _____

Any other allergies? _____

Are you pregnant or have you been pregnant in the last 3 months? YES NO

Have you had any surgeries? NO YES _____

Do you use tobacco, alcohol, or other substances? YES NO

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

	Yes	No
Allergies	Y	N
Arthritis	Y	N
Blood/Lymph	Y	N
Bronchitis	Y	N
Cancer	Y	N
Cholesterol	Y	N
Diabetes	Y	N
Digestive	Y	N
Ears/Nose/Throat	Y	N
Endocrine	Y	N
Eczema/Rashes	Y	N
Fatigue	Y	N
Fevers	Y	N
Genitourinary	Y	N
Heart Problems	Y	N
High Blood Pressure	Y	N
Integumentary (Skin)	Y	N
Kidney	Y	N
Muscle/Bone	Y	N
Neurological	Y	N
Psychological	Y	N
Respiratory	Y	N
Sinus	Y	N
Throat Infections	Y	N
Thyroid	Y	N
Unusual weight losses/gains	Y	N

Patient Eye History

Date of Last Eye Exam _____

By Whom? _____

If you wear bifocals, do the lines or head tilting bother you? 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

Have you ever tried contact lenses? YES NO

Would you like to try contact lenses? YES NO

Would you prefer clear contact lenses or colored contact lenses? CLEAR COLORED

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

- | | |
|--|--|
| <input type="checkbox"/> Blurry vision | <input type="checkbox"/> Burning |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Corneal abrasions |
| <input type="checkbox"/> Crossed eye/Eye turn | <input type="checkbox"/> Double vision |
| <input type="checkbox"/> Eye infections | <input type="checkbox"/> Eye injury |
| <input type="checkbox"/> Flash of light | <input type="checkbox"/> Floaters/Spots |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Grittiness |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Iritis/Uveitis |
| <input type="checkbox"/> Itchiness | <input type="checkbox"/> Lazy Eye |
| <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Allergy Eye |
| <input type="checkbox"/> Retinal Detachment | <input type="checkbox"/> Sunlight sensitivity |
| <input type="checkbox"/> Tearing | <input type="checkbox"/> Trouble seeing at night |
| <input type="checkbox"/> Uncomfortable glasses | <input type="checkbox"/> Dry eye |
| <input type="checkbox"/> Other eye disorders | _____ |

Family Medical/Eye History (Check all that apply)

Is there a **family medical history** of any of the following? (any blood relatives)

NO YES (please check boxes & indicate relationship)
(Mothers or Fathers side)

- Diabetes _____
- High Blood Pressure _____
- Cancer _____
- Thyroid Conditions _____
- Glaucoma _____
- Cataracts _____
- Blindness _____
- Macular Degeneration _____
- Corneal Problems _____
- Lazy Eye _____
- Retinal Problems _____

I hereby authorize my insurance benefits to be paid directly to the physician and I agree to be financially responsible for any non-covered service including deductibles and co-pays. I am also aware that I am responsible for any costs incurred in collection of any non-assigned fees. I authorize the physician to release any information required to process my insurance claims. I acknowledge that I am aware of or received a copy of 20/20 Eyecare Centers Notice of Privacy Practices.

Signature _____ Date _____