PATIENT INFORMATION FORM **Exam Date / /**

Last Name _______________ First Name _______________ M / F Birth Date / /

Address _________________________ City _______________ State ____ Zip Code ________Email ___________________

Home Phone ( ) _____________________ Work Phone ( ) _______________________ Cell ( ) ___________________

Employer _______________________ Occupation ___________________________ Referred By _____________________

INSURANCE INFORMATION

Insurance Name_______________________ Group # ___________ ID#________________Insured DOB _____________

Patient SS# _________________ Primary Insured Name____________________ Primary Insured SS# _________________

MEDICAL AND OCULAR HISTORY

Reason for today's exam? ____

Are you planning on purchasing new eye glasses today? Y/N Are you planning on purchasing contacts today? Y/N

Age of present glasses ____ Age of Sunglasses ____Date of Last Eye Exam / / Dr. ___________ Previous Patient? Y / N

PATIENT/FAMILY MEDICAL HISTORY	**Self**	**Relative**	**None**	**LIFESTYLE QUESTIONS**	**Yes**	**No**
Diabetes	☐	☐	☐	Work at computer? How many hours a day? _____	☐	☐
High Blood Pressure	☐	☐	☐	Think will benefit from thinner/lighter lenses	☐	☐
Thyroid Problems	☐	☐	☐	Spend time outdoors (if yes, how much)	☐	☐
Heart Disease	☐	☐	☐	Have RX Sun Wear	☐	☐
Asthma	☐	☐	☐	Prefer not to wear glasses at certain times	☐	☐
Cancer	☐	☐	☐	Do you suffer from Dry Eye? Y / N	☐	☐
HIV	☐	☐	☐	Currently have multiple RX glasses	☐	☐
Glaucoma	☐	☐	☐	Have family members in need of eye care	☐	☐
Cataracts	☐	☐	☐	Have small children	☐	☐
Retinal Disease	☐	☐	☐	Do you wish to wear glasses all the time	☐	☐
Eye Surgery	☐	☐	☐	Do you use multiple computers at work or home	☐	☐
Eye Injury	☐	☐	☐	☐ Smoker ☐ Former Smoker	☐	☐
High Cholesterol	☐	☐	☐	*Brand of Current Contact Lens (if contact wearer)* ____________________		

Other ____

Please explain any positive medical findings ____

____

Eye drops currently taking (OTC or RX) ____

Medications (OTC and/or RX) ____

____

Do you have any allergies? If yes, what medications or treatment are you currently on? _____________________________

Are you allergic to any medications? YES NO List medications allergic to ____

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PAYMENT POLICY FOR SERVICES AND MATERIALS

If you are using insurance coverage for today's visit, this is a contract between you and your insurance company. We will submit whatever we can to assist the process but if Eyeworks is not reimbursed in full, or paid by your insurance company, the balance is your responsibility. If there is any question of coverage, you may be required to pay at time of visit or post visit IF payment is received from your insurance company, you may be eligible for a refund or partial refund of payment. Payment for all services are due at time services are rendered. ***All sales on services and materials are FINAL.*** *Deposits not paid in full or materials left for more than 120 days after order will be forfeited. MEDICARE PATIENTS ONLY: Medicare pays 80% of the allowed fee and the patient is responsible for the other 20% of U&C of exam fee. Medicare patients are also responsible for the annual Medicare deductible and all non-covered services (including refraction fee).* .

(Pt Initial)_____________

I understand and agree to Eyeworks Policies:

Signature Date

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