Davis Optical & Family Eye Health Center

Welcome To Our Office

Patient Information

Today's Date ______________________________
Last Name ______________________________
First Name ____________________ MI __________
Date of Birth ____________________ Age __________
Gender M F Height ________ Weight ________
Preferred Language ______________________________
Race: ❑American Indian or Alaska Native ❑Asian
❑African American ❑Caucasian
❑Native Hawaiian or Other Pacific Islander
Ethnicity: ❑Hispanic or Latino ❑Not Hispanic or Latino
Last 4 digits of SSN __________
Address ______________________________
City ______________ State _____ Zip Code _________
Home Phone ______________________________
Work Phone ______________________________
Mobile Phone ______________________________
Email Address ______________________________
How do you prefer to be contacted? (Please check all that apply)
Home _____ Work _____ Mobile _____ Email _____
May we add you to our *Educational*, *Sales and Promotions* E-mailing list? ❑Yes ❑No
Employer (or School) ______________________________
Occupation (or Grade) ______________________________
Spouse (or guardian's) Name ______________________________
Spouse (or guardian's) Employer ______________________________
Spouse (or guardian's) Date of birth ______________________________

Very Important - What is the major purpose of your visit today?
____

Any problems or complaints with your eyes, glasses or contact lenses? ______________________________
____

New Patients Only:
Who may we thank for referring you to our office?
Name of friend, relative or other Dr.________________
If not referred, how did you choose our office?
❑ Saw Sign/Building/Location ❑ Insurance List
❑ Newspaper ❑ Yellow Pages
❑ Web Page: Which Web Site? ______________________

Dry Eye Survey (Please answer: Never, Rarely, Sometimes, Often or All the Time)

1. Do your eyes ever feel dry? ____________________
2. Do you ever feel a gritty or sandy sensation in your eyes? ______________________________
3. Do your eyes ever burn? ____________________
4. Are your eyes ever red? ____________________
5. Do you notice any crusting on your lashes? ______________________________
6. Are your eyes ever glued shut in the morning? ______________________________

Insurance Information

Please give your insurance card(s) to the front desk

Primary Vision Insurance ______________________
Subscriber Name ______________________________
Subscriber ID ______________________________
Subscriber Birth Date __________ Group # __________
Relationship to Patient ______________________________
Secondary Vision Insurance ______________________
Subscriber Name ______________________________
Subscriber ID ______________________________
Subscriber Birth Date __________ Group# __________
Relationship to Patient ______________________________
Primary Medical Insurance ______________________
Subscriber Name ______________________________
Subscriber ID ______________________________
Subscriber Birth Date __________ Group# __________
Relationship to Patient ______________________________
Secondary Medical Insurance ______________________
Subscriber Name ______________________________
Subscriber ID ______________________________
Subscriber Birth Date __________ Group# __________
Relationship to Patient ______________________________

Lifestyle Questions

Do you: (check box if your answer is yes)
❑ work at a computer?
❑ think you might benefit from thinner, lighter lenses?
❑ have interest in the latest contact lens designs?
❑ spend time outdoors? How much?_____ Hrs/week
❑ have prescription sunwear?
❑ participate in sports activities?__________________
❑ prefer not to wear your glasses at times?
❑ want information on Laser Vision Correction surgery?
❑ have more than 1 pair of current Rx eyewear?
❑ have family members in need of eyecare?
❑ have hobbies?______________________________

Have you ever experienced, been diagnosed or treated for any of the following?
❑ Blurry Vision ❑ Burning
❑ Cataracts ❑ Corneal Abrasions
❑ Crossed Eye/Eye Turn ❑ Double Vision
❑ Eye Infections ❑ Eye Injury/Trauma
❑ Flashes of Light ❑ Floaters/Spots
❑ Glaucoma ❑ Grittiness
❑ Headaches ❑ Iritis/Uveitis
❑ Itchiness ❑ Lazy Eye
❑ Macular Degeneration ❑ Occasional Dryness
❑ Retinal Detachment ❑ Sunlight Sensitivity
❑ Tearing ❑ Trouble Seeing at Night
❑ Eye strain

❑ Previous Eye Surgeries? ______________________
❑ Other Eye Disorders ______________________

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________________________
Phone #______________________________________
Address______________________________________
Date of Last Physical Check-up___________________

CURRENT MEDICATIONS (Rx or Over the Counter)
Please list all medications including eye drops, vitamins, & birth control pills etc…

Medication:	**Dosage:**	**Taken for:**

Allergies to medications? ❑ Yes ❑ No
If so, what?___________________________________
____

Other Allergies? ________________________________
____

Do you now or have you ever used cigarettes/tobacco?
❑ Yes ❑ No ________________________________

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

	Yes	No
Arthritis (Type):____________	❑	❑
Asthma	❑	❑
Blood/Lymph Condition	❑	❑
Bronchitis	❑	❑
Cancer (Type):____________	❑	❑
Cholesterol	❑	❑
Diabetes: Type I___ Type II___	❑	❑
When diagnosed?_________		
Digestive	❑	❑
Chronic Sinus	❑	❑
Eczema/Rashes	❑	❑
Chronic Fatigue	❑	❑
Chronic Fevers	❑	❑
Genitourinary	❑	❑
High Blood Pressure	❑	❑
When diagnosed?_________		
HIV	❑	❑
Kidney	❑	❑
Muscle/Bone	❑	❑
Neurological	❑	❑
Psychological	❑	❑
Thyroid	❑	❑
Unusual Weight Losses/Gains	❑	❑

Other ___________________________________

PATIENT EYE HISTORY

Date of Last Eye Exam____________________________
By Whom?______________________________________

Have you ever worn glasses? ❑ Yes ❑ No
If you wear bifocals, do the lines or head tilting bother you? ❑ Yes ❑ No
Have you ever tried contact lenses? ❑ Yes ❑ No
If no, are you interested in contacts? ❑ Yes ❑ No
Do you currently wear contact lenses? ❑ Yes ❑ No
What kind?_____________________________________
Solutions used___________________________________
Do you wear your contacts overnight? ❑ Yes ❑ No

Are you satisfied with the vision and comfort of your contact lenses? ❑ Yes ❑ No
Would you prefer clear contact lenses or colored contact lenses? ❑ Clear ❑ Colored

Family Medical/Eye History (Check all that apply)

Is there a family medical history of any of the following:
(Please check boxes)

	Specify Relationship (ie: Maternal Grandmother)
Blindness	❑_____________________
Cataracts	❑_____________________
Corneal Problems	❑_____________________
Diabetes	❑_____________________
Glaucoma	❑_____________________
Heart Disease	❑_____________________
High Blood Pressure	❑_____________________
Lazy Eye	❑_____________________
Macular Degeneration	❑_____________________
Retinal Problems	❑_____________________

Release of Benefits and Information:
I certify that the above questions have been accurately answered to the best of my knowledge. I authorize and request my insurance benefits to be paid directly to Davis Optical & Family Eye Health Center**. I acknowledge that any insurance benefits quoted to me are an estimate only, not a guarantee of payment and I am financially responsible for any balance due**. (*Please note that some insurance companies do NOT cover the Contact Lens Measurement and Follow-Up Evaluation).* I authorize the doctor or insurance company to release any information required to file a claim**. I agree to be responsible for payment of all services rendered on my behalf or my dependents.**

Signature ______________________ Date__________