



## Welcome to our Office!

The mission of Modern Eye Care is to contribute to a lifetime of healthy vision, providing each patient with the highest quality vision care and consequent 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. Everything we do shall communicate this. The information and questions below will remain confidential, and are critical to the evaluation of your vision and health. Therefore it is very important that every question be answered in detail. Thank you.

### Patient Information

TODAY'S DATE: \_\_\_\_\_

NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ AGE: \_\_\_\_\_ SEX: M F

ADDRESS: \_\_\_\_\_ SS#: \_\_\_\_\_  
 (street) (city) (state) (zip)

EMAIL: \_\_\_\_\_ HOME PHONE: \_\_\_\_\_ CELL/WORK PHONE: \_\_\_\_\_

NAME/LOCATION OF PRIMARY CARE PHYSICIAN: \_\_\_\_\_ DATE OF LAST EXAM: \_\_\_\_\_

NAME/LOCATION OF LAST EYE EXAM: \_\_\_\_\_ DATE OF LAST EXAM: \_\_\_\_\_

EMPLOYER/SCHOOL: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_ IF STUDENT: GRADE: \_\_\_\_\_

NAME OF SPOUSE/PARENT (Please Circle): \_\_\_\_\_ SPORTS/HOBBIES: \_\_\_\_\_

VISION INSURANCE: \_\_\_\_\_ MEDICAL INSURANCE: \_\_\_\_\_ FLEX SPENDING?: YES NO

ALLERGIES TO MEDICATIONS?  NONE  YES: Please List: \_\_\_\_\_

CURRENT MEDICATIONS:  NONE  YES: \_\_\_\_\_  
 including prescription, over the counter, natural herbs, vitamins, and birth control

DO YOU USE: TOBACCO PRODUCTS?  YES  NO DRINK ALCOHOL?  YES  NO USE DRUGS?  YES  NO

IF YES, TYPE/AMOUNT/HOW LONG: \_\_\_\_\_

#### CHECK ANY MEDICAL CONDITIONS THAT APPLY TO YOU

- Diabetes
- High Blood Pressure
- High Cholesterol
- Heart Disease
- Vascular Disease/Stroke
- Seizures
- Lung Disease/Asthma
- Headaches/Migraines

#### NONE Except Below:

- Cancer
- Thyroid Disease
- Arthritis
- Weight Loss/Gain
- Skin Eczema/Rash
- Kidney/Bladder
- Psychiatric
- Autoimmune

#### CHECK ANY EYE CONDITIONS THAT APPLY TO YOU

- Glaucoma
- Cataracts
- Macular Degeneration
- Dry Eyes/Allergies

#### NONE Except Below:

- Turned Eyes
- Eye Injury
- Eye Surgery
- Other \_\_\_\_\_

#### CHECK CONDITIONS THAT ARE PRESENT IN OTHER FAMILY MEMBERS

- Glaucoma
- Cataracts
- Macular Degeneration
- Retinal Detachment
- Turned/Crossed Eyes
- Lazy Eye

#### NONE Except Below:

- Blindness
- Diabetes
- High Blood Pressure
- Cancer
- Heart Disease
- Thyroid Disease

#### WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE

Name of Friend/Relative: \_\_\_\_\_

- Insurance Listing
- Saw Sign/Building
- Newspaper Ad
- Yellow Pages
- Flyer
- Coupon Mailer
- Another Doctor's Office recommendation
- Web Page: Which website?
- Other \_\_\_\_\_

**WHAT ARE THE MAIN REASONS FOR TODAY'S APPOINTMENT? (PLEASE CHECK ONE OR MORE)**

- ( ) Distance blurred vision ( ) Dry/Burning eyes ( ) Eye Pain or Soreness ( ) One eye turns in or out
( ) Near blurred vision ( ) Eye Watering or Tearing ( ) Foreign matter in eyes ( ) Seeing flashes of light
( ) Sudden loss of vision ( ) Unusual Light Sensitivity ( ) Eyelids matted shut ( ) Floating spots in vision
( ) Frequent eyestrain ( ) Eye Itching or Allergies ( ) Mucous Discharge eyes ( ) Contact lens discomfort
( ) Frequent headaches ( ) Red eyes ( ) Double vision ( ) Other \_\_\_\_\_

**LIFESTYLE QUESTIONNAIRE (PLEASE CHECK Yes or No)**

- Are you planning on purchasing glasses at your visit? ( ) Yes ( ) No ( ) Only if there is a Change
Do you have problems with your current glasses or contacts? ( ) Yes ( ) No
Do your eyes tire quickly while reading? ( ) Yes ( ) No
Do you spend time/work outdoors? ( ) Yes ( ) No How many Hrs/Wk? \_\_\_\_\_
Do you have trouble with night driving? ( ) Yes ( ) No
Do you use a computer? ( ) Yes ( ) No How many Hrs/Day? \_\_\_\_\_
Are your eyes sensitive to sunlight/bright light? ( ) Yes ( ) No
Do you have prescription sunglasses? ( ) Yes ( ) No
Do you think you might benefit from thinner/lighter lenses? ( ) Yes ( ) No
Do you prefer not to wear your glasses at times? ( ) Yes ( ) No
Are you interested in Laser Vision Correction ( ) Yes ( ) No
Are you interested in nonsurgical vision correction? ( ) Yes ( ) No
Do you have more than 1 pair of current prescription glasses? ( ) Yes ( ) No
Do you have children? ( ) Yes ( ) No
Do you have family members in need of eyecare? ( ) Yes ( ) No
Do you participate in any activities that may put your eyes in danger? ( ) Yes ( ) No

**COMPUTER USER QUESTIONNAIRE:** Do you notice any of these visual problems while at the computer?

- ( ) Headaches during or after working at the computer ( ) Distance vision blurry when looking up from the computer
( ) Burning eyes ( ) Letters on the screen run together
( ) Dry, tired, or sore eyes ( ) Need to rest eyes frequently at work
( ) Overall bodily fatigue or tiredness ( ) Driving/night vision worse after computer use
( ) Neck, shoulders, or back pain ( ) "Halos" appear around objects on the screen

Many people experience a variety of symptoms after working at their computer for some period of time. If you answered yes to any of the questions above, there is a new type of eyewear lens that can eliminate the symptoms and dramatically improve your comfort level when working on a computer. These eyewear lenses result from a new vision testing technology, developed specifically for computer users, which our office has been trained and certified to use. Please make sure to discuss these issues with the doctor.

**CONTACT LENS HISTORY and QUESTIONNAIRE (check all that apply):**

- ( ) I am not interested in contact lenses
( ) I have never worn contacts, but I am interested in wearing contact lenses and would like to discuss my options
( ) I am not satisfied with the comfort of my current contact lenses
( ) I am not satisfied with the vision of my current contact lenses
( ) I currently wear contact lenses; If so, what type: \_\_\_\_\_ Solution: \_\_\_\_\_ Sleep in your lenses? YES NO

How often do you replace your contacts? DAILY BI-WEEKLY MONTHLY BI-MONTHLY QUARTERLY YEARLY

**OPTOMAP Retinal Exam:** Our doctors order this crucial test as part of your comprehensive eye exam. This advanced technology is used by the doctors to detect early signs of retinal disorders, including but not limited to: glaucoma, cancer, diabetic retinopathy, high blood pressure, macular degeneration, and retinal detachment. By performing this test, the doctors will likely not dilate your eyes unless the test reveals undetected eye disease. It is particularly helpful when you return for your annual exam as it provides a permanent record of your retinal condition, and each subsequent year the OPTOMAP images can be viewed side by side to discover subtle changes and monitor your continuing eye health. There is a \$38 copay associated with this procedure that some insurances do cover.

**Receipt of Notice of Privacy Policies & Consent Form**

I acknowledge that I have received the Notice of Privacy Practices from Modern Eye Care. I have read this document and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations. I authorize the same to assignment of benefits from my insurance company. I also understand that the premises are under video surveillance, and that these recordings will be kept strictly confidential. They may be used by Modern Eye Care in any way deemed necessary, including use by law enforcement and in a court of law.

Please be advised if you are using insurance coverage for today's visit, this is a contract between you and your insurance company, not Modern Eye Care. If your insurance company has not reimbursed our office in full within 90 days, you may be billed and your insurance company will then pay you directly. If by mistake your insurance company sends the payment check to us, we will of course sign over and forward the check directly to you. Please sign below acknowledging that you understand:

Signature: \_\_\_\_\_