Eyedare Optometry

PATIENT INFORMATION

Name _____ Date _____

Date of Birth _____ Age _____ Occupation _____ Gender _____

CONTACT INFORMATION

Address _____

City _____ State ____ ZIP Code _____

Cell Phone _____ Other Phone _____

Preferred Method of Contact ☐ Cell Phone ☐ Texting_Allowed

DO YOU HAVE HAVE VISION INSURANCE? ☐ YES ☐ NO

*If **YES** for vision insurance please complete Purple Highlighted area*

*If **NO** please skip Purple Highlighted area.*

SELECT YOUR VISION INSURANCE (CHECK ONE) ☐ **VSP** ☐ **EyeMed**

WE CAN BILL DIRECTLY TO (VSP) AND (EyeMed) ALL OTHER PLANS WILL RECEIVE DOCUMENTATION THAT CAN BE SUBMITTED DIRECTLY FOR REIMBURSEMENT.

IF YOU WORK FOR GOOGLE, APPLE OR WELLSFARGO PLEASE INCLUDE YOUR EMPLOYEE ID.

Primary's Name: _____ Date of Birth: _____ Employee ID # _____ Subcriber ID: _____ Last 4 digits of SSN: _____

IF YOU HAVE A CIGNA OR UNITED HEALTHCARE CARD IT MIGHT BE LINKED TO THAT ID NUMBER

CIGNA OR UNITED HEALTHCARE CARD #

What is the main reason for your visit ? _____

When was your last complete eye exam? _____

Read each question and check if applicable to you.

Yes	No	
☐	☐	I am pregnant.
☐	☐	I have difficulty with night vision or night driving.
☐	☐	I am excessively bothered by sunlight, bright lights, or glare.
☐	☐	I spend time at a computer.
☐	☐	I experience frequent headaches.
☐	☐	I have had a recent illness or been hospitalized in the last 2 years. *If YES, why?* _____
☐	☐	I have environmental allergies, sinus trouble, or hay fever.
☐	☐	I am allergic to medications. *If YES, what medications?* _____
☐	☐	I have had an eye infection, eye injury, **or eye surgery (including LASIK)** *If YES, when?* _____
☐	☐	I'm interested in Lasik. *If YES, when?* _____
☐	☐	I experience flashes of light or floaters or I have had a head injury in the past. *If YES, how often?* _____
☐	☐	I use eyedrops. If YES, please list? _____
☐	☐	I recently had sudden onset of major vision loss, pain or double vision. *If YES, when did it start?* _____
☐	☐	I have worn contact lenses in the past but no longer wear them currently. *If YES, what type of contact lens?* _____
☐	☐	I currently wear contact lenses. Do you sleep with your contacts? If YES, what brand and prescription (if known)? _____

Rate your current lens comfort (if applicable). ☐ Good ☐ Poor

Rate your current vision with contact lenses. ☐ Clear ☐ Blurred

Any additional information you would like to share regarding contacts.

MEDICAL AND OCULAR HISTORY

Check if applicable to you or your blood relative(s).

	You (Patient) Yes	You (Patient) No	Blood Relative(s) Yes	Relation to Patient: Examples (Paternal Grandmother, Maternal Grandfather, Father, Mother, Sister, Brother, Aunt, Uncle)
Diabetes	☐	☐	☐	_____
High Blood Pressure	☐	☐	☐	_____
Heart Problems	☐	☐	☐	_____
Asthma	☐	☐	☐	_____
Cataracts	☐	☐		_____
Retinal Detachment	☐	☐	☐	_____
Blindness	☐	☐	☐	_____
Lazy or Crossed Eyes	☐	☐	☐	_____
Glaucoma	☐	☐		_____
Macular Degeneration	☐	☐		_____

Other ocular (eye) problems: _____

Other general health problems: _____

List All Medications: _____

PLEASE PROVIDE YOUR EMAIL ADDRESS IF YOU WANT ANY PATIENT INFORMATION SENT TO YOU. (LEAVE BLANK IF YOU DECLINE)

EMAIL:

Patient Notes for Staff or Optometrist

Previous Glasses:
What did you like and not like from your previous pair?

I have read and understand the privacy policies of Eyedare Optometric.

Patient Signature or Guardian Signature _____ **Date** _____

Print Name of Parent/Guardian: _____

Relationship to Patient: _____