RETURNING PATIENT

PLEASE PRINT Today's Date: ____________

Name_________________________________ M.I.____

Date of Birth ___________________ Age _____________

Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐
Student? Yes ☐ No ☐
Employed? Yes ☐ No ☐ Retired ☐

Job Title ____

Employed by ____________________________________

Describe what you do: ____________________________

_____________________, Hobbies: __________________

Please note that your insurance benefits are based on a contract between you and your insurance company. Any disputes about your benefits are between you and them, not between you and us. Financial responsibility for co-payments and non-covered services or products remains with you. Full payment, less anticipated insurance coverage, must be received before materials are dispensed. If you have questions regarding your insurance, please call the member services department listed on your card or contact your Human Resources Department.

(Your "Vision" insurance covers you for common vision focusing problems, glasses or contact lenses, but will not cover treatment for medically based eye conditions. Those types of problems are billed to your "Medical" insurance.)

Vision Insurance: ☐ Avesis ☐ BC/BS ☐ CIGNA
☐ Davis including FEP, GE, Highmark ☐ EyeMed
☐ Medicare ☐ Spectera ☐ Superior ☐ United Healthcare ☐ TriCare ☐ VBA ☐ VSP
☐ Amerigroup/OptiCare/PeachCare/WellCare

If you have Medicaid, do you have other health ins.? Y N

☐ Other: ____________________________________

Medical Insurance

Insurance Plan _______________________________

Insured's Name _______________________________

Insured's ID# or SS# __________________________

Insured's Date of Birth _________________________

Patient's Relationship to Insured:
Self ☐ Spouse ☐ Child ☐

Please give receptionist your MEDICAL CARD

REASON FOR TODAY'S VISIT:

☐ Routine Eye Examination ***and / or*:**
☐ Want New Glasses ☐ Want More Contacts
☐ Want Contact Lenses: 1st time
☐ Other: ___________________________________

____

	YES	NO
Do you routinely wear sunglasses?	☐	☐
If you wear contacts, do you have glasses	☐	☐
Do you often have dry eyes?	☐	☐
Do you use *any kind* of eye drops?	☐	☐
Do you smoke?	☐	☐
Do you have headaches? (# per week _____)		☐

Are you prepared to have your eyes dilated today?
☐ YES ☐ NO

Dilation helps the doctor see inside your eyes. The need for dilation depends on a number of factors including your age, your general health, the natural size of your pupils, and the length of time since your last dilation. The effects of dilation last 3-5 hours and include light sensitivity and distorted vision especially when reading.

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Check any that apply to you or a family member:
☐ Color Blind: who _________________________
☐ Glaucoma: who __________________________
☐ Macular Degeneration: ____________________

Check any health problems you are being treated for
☐ Diabetes using: Pills ☐ Insulin injections ☐
☐ Hypertension ☐ High Cholesterol
☐ Heart Problem ___________ ☐ Cancer ______
☐ Arthritis ☐ Asthma ☐ COPD ☐ Allergies
☐ Anxiety ☐ Depression ☐ Kidney/Liver
If pregnant, how many months? _______

* * * * * * * * * * * * * *

If your ADDRESS or PHONE NUMBER HAS CHANGED, FILL OUT CHANGES BELOW

Street_____________________________________

City ______________________________________

ZIP _________ Best # to Contact You

Phone: Home ________________________ ☐

Phone: Daytime ______________________ ☐

Phone: Cell _________________________ ☐

E-Mail Address ___________________________

(TURN OVER TO OTHER SIDE)

RETURNING PATIENT

List any prescription medications you are taking and what they are for:

Name: ___________________ Dosage: ________________ To treat: _____________________

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Name: ___________________ Dosage: ________________ To treat: _____________________

Name: ___________________ Dosage: ________________ To treat: _____________________

Name: ___________________ Dosage: ________________ To treat: _____________________

List any Supplements or Vitamins you are taking:

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____

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Are you allergic to any medications? No ☐ Yes ☐

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