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: _____

Heavy Computer user? Yes No

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 Plan" 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. In some instances, both might need to be billed.)

Vision Insurance: Avesis BC/BS CIGNA
Davis including FEP, GE, Highmark EyeMed
Medicare Superior United Healthcare
TriCare VBA VSP
Amerigroup/Envolve/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 4-5 hours and include light sensitivity and distorted vision especially when reading.

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

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, PHONE NUMBER or e-mail HAS CHANGED, FILL OUT CHANGES BELOW

Street_____
City _____
ZIP _____ Best # to Contact You
Phone: Home _____
Phone: Daytime _____
Phone: Cell _____
E-Mail Address _____

RETURNING PATIENT

List any **prescribed** Medications or Vitamins/Supplements you are taking and what they are for,

or **I am not taking any ?**

Name: _____ Dosage: _____ To treat: _____

Name: _____ Dosage: _____ To treat: _____

Name: _____ Dosage: _____ To treat: _____

Name: _____ Dosage: _____ To treat: _____

Name: _____ Dosage: _____ To treat: _____

Name: _____ Dosage: _____ To treat: _____

Name: _____ Dosage: _____ To treat: _____

Name: _____ Dosage: _____ To treat: _____

Name: _____ Dosage: _____ To treat: _____

List any **non-prescribed** Medications, Supplements or Vitamins you are taking:

_____

_____

_____

_____

_____

Are you allergic to any medications? **No** **Yes**

_____

_____

_____

_____