

Welcome to our office. We are glad that you have chosen us to provide your eye-care needs. Please complete this form and bring it with your eye exam or, to expedite insurance coverage approvals, return it prior to the eye exam by any of the following methods:

Online — by using the Submit button at the end of this form

Fax — to 954-564-3869

PATIENT INFORMATION AS OF TODAY'S DATE ___/___/20___

Please print

Date _____

Mr. Mrs. Ms. Dr.

Name _____

Address _____

City _____ State _____ Zip+4 _____

Home Phone _____

Work Phone _____

Cell Phone _____

Occupation _____

Date of Birth ___/___/___ Age _____

Social Security # _____ - _____ - _____

Family Physician _____

Address _____

Referred by _____

Have you ever been to this office before? No Yes

Approximate date of last eye examination _____

By Doctor: _____

If the Patient is a Minor

Grade _____ School _____

Responsible Person for Payment _____

VISION OR MAJOR MEDICAL INSURANCE INFORMATION

Plan Name _____

Insured's Name _____

Member ID # _____

Group # _____

Patient's relationship to insured _____

We will file insurance for any plan under which we are providers. If you have a question about which plans for which we are providers, please ask our receptionist. Payment is expected at time of treatment.

PAYMENT INFORMATION

Driver's license # (if paying by check) _____

Payment Preference:

Cash Check Visa MC AMEX Discover

CONTACT LENS PATIENTS

Have you ever worn contact lenses in the past?	No	Yes
Do you currently wear contact lenses?	No	Yes
Are you interested in lenses, which enhance or change your eye color?	No	Yes
Do you want to nap or sleep in your lenses?	No	Yes
Do your eyes become dry, itchy or irritated while wearing contacts?	No	Yes
Do your contacts become less comfortable as the day progresses?	No	Yes
Are you interested in learning about the latest advances in contact lenses?	No	Yes

Type of lenses worn: Soft Extended Wear Gas Permeable
Hard Bifocal Toric (astigmatism) Disposable Other

Age of present contact lenses: _____

Date of last contact lens exam: _____

How many hours per day do you wear your contacts? _____

What contact lens cleaning solution are you using:

PERSONAL HISTORY

Glasses worn: Do not wear Wear full time Distance/driving only
Near/reading

Age of present glasses: _____ Last exam date: _____

from Dr. _____

Occupation: _____

Hobbies: _____

Would you be interested in maintenance-free contact lenses for part-time wear?

No Yes

Do you spend time on a computer? No Yes If yes, how many hours per day? _____

Have you been treated or diagnosed for any of the following conditions?

Diabetes Glaucoma High blood pressure

Cataracts Thyroid problems Blindness

Heart disease Allergies Eye disease/infections

Double vision Eye or head injuries Amblyopia

Trauma or car accidents _____

Allergies Kidney problems Strabismus
Drug sensitivities Seizures
Skin conditions Respiratory Problems Cancer
High cholesterol High Triglycerides Migraines
Macular degeneration Other _____

Do you have any current health problems? No Yes If yes, please list below:

Please list any medications you are currently taking (*include hormones, vitamins, birth control pills or any eye drops*).

Are you allergic to any medications, food or pollen? No Yes

If yes, please list below:

If you have had an eye infection, eye injury, or eye surgery, please describe:

Have you ever had any surgery elsewhere? If so, please describe

Have you ever experienced any head or eye trauma or car accident(s)? If so, please describe:

If you are currently being treated for any medical conditions, please describe:

Last general health exam date _____

Have you every received vision training or eye exercise? Yes No

Please check any symptoms that you have been experiencing:

Frequent headaches	Double vision	Dizziness
Flashing lights	Eye pain	Itching
Burning	Tearing	Twitching
Light sensitivity	Aching	Floaters

Blurry sensitivity Blurry Intermediate or Near Vision

Charges for eye medical services, eyeglasses and/or contact lenses are due and payable at the time that services and/or eyeglasses or contact lenses are dispensed. Our office will be happy to assist you in filing your insurance form. Collection costs and/or reasonable attorney fees will be due in the event that any collection process becomes necessary.

I request that payment of authorized Medicare benefits or other insurance be made either to me or on my behalf to Dr. Easton for any services furnished to me by that doctor. I authorize any holder of medical information about me to release to the health care financing administration and its agents, any information needed to determine these benefits or the benefits payable for related services.

Lifetime Patient Signature _____

Date _____

Family History

Has anyone in your family been treated or diagnosed for any of the following conditions? If so, please state their relationship to you.

Diabetes _____

Glaucoma _____

High blood pressure _____

Cataracts _____

Thyroid problems _____

Blindness _____

Heart disease _____

Cancer _____

Keratoconus _____

Macular Degeneration _____

Strabismus _____

Kidney Problems _____

Stroke _____

Other _____

