

Premier Eyecare
Welcome To Our Office
Please Print

Patient's Name _____ Age _____ Today's Date ____/____/____
Last First Middle Initial

If Married, Name of Spouse _____ If Child, Parents Name _____

Address _____ City _____ State _____ Zip Code _____

Phone: H _____ W _____ Social Security # _____ / _____ / _____ Date of Birth _____

First Visit here? Yes _____ No _____ Previous Doctor _____ Date of Last Exam ____/____/____

Reason For Today's Visit _____ Are you interested in contact lenses? Yes _____ No _____

Have you previously worn contacts? Yes _____ No _____ If so, what kind? _____

Primary Insurance _____ Insured's Name _____ Insured's Date of Birth _____

Place of Employment _____ Contract # _____ Group # _____

Secondary Insurance _____ Insured's Name _____ Insured's Date of Birth _____

Place of Employment _____ Contract # _____ Group # _____

OCULAR HISTORY

Change in Vision: Yes _____ No _____	Cataracts: Yes _____ No _____	Itching or Burning: Yes _____ No _____
Double Vision: Yes _____ No _____	Glaucoma: Yes _____ No _____	Distorted Vision/Halos: Yes _____ No _____
Spots or Floaters: Yes _____ No _____	Eyelid Problems: Yes _____ No _____	Eye Pain or Soreness: Yes _____ No _____
Excess Tearing: Yes _____ No _____	Tired when reading: Yes _____ No _____	Glare/Light Sensitivity: Yes _____ No _____
Dry Eyes: Yes _____ No _____	Loss of Side Vision: Yes _____ No _____	Color of Eyes: _____

MEDICAL HISTORY

Heart Disease: Yes _____ No _____	Lung Disease: Yes _____ No _____	Lupus: Yes _____ No _____
High Blood Pressure: Yes _____ No _____	Cancer: Yes _____ No _____	Asthma: Yes _____ No _____
Kidney Disease: Yes _____ No _____	Sinus Problems: Yes _____ No _____	Other (please list) _____
Ulcers: Yes _____ No _____	Headaches: Yes _____ No _____	_____
Thyroid Problems: Yes _____ No _____	Allergies (please list) _____	_____
Diabetes: Yes _____ No _____	_____	_____

Are you taking any medications? (please list) _____

Do you work on a computer? Y ___ N ___ Do you have trouble with glare? Y ___ N ___ While driving at night? Y ___ N ___

Do you want to have your eyes Dilated? Yes _____ No _____ If necessary _____

Have you ever had an adverse reaction to Dilation? Yes _____ No _____

Insurance:

As a courtesy to our patients we will take assignment on your vision benefits designated by your insurance plan. However, patients are financially responsible for non-covered services, including co-pays and non-payment by the insurance. Payment is due in full when services are rendered. Eyeglass and contact lens prescriptions are valid for 12 months from the exam date. Contact lens exam includes two follow-up visits within a sixty day period. Each additional follow up visit will include a \$25.00 fee. New patients or those who are fit in a different contact lens must have a follow-up visit before contact lens prescription will be finalized. Exam fees are not refundable under any circumstances. All health information is considered private and will not be released without the patient's authorization. I attest the above information to be true and understand the terms stated above.

Please sign: _____