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 # (last four) ________ 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____ High Cholesterol: Yes____ No____
Ulcers: Yes____ No____ Headaches: Yes____ No____ Other (please list) __________
Thyroid Problems: Yes____ No____ Alleriges (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. 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. Measurements including segment height and pupillary distance (pd) will not be released. 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: ______________________________