

CURRENT PATIENT UPDATE

Last		First	
Residence Address	City	State	Zip Code
Residence Phone	Cell Phone	Email Address	
Business Phone	Employer	Occupation	
Spouse's Name		Spouse's Occupation	
Date of Last Eye Exam		Eye Doctor's Name (City & State)	

INSURANCE UPDATE

Amerigroup Avmed Beechstreet Blue Cross Cigna CompBenefits Davis
 Healthy Kids Medicaid Medicare Medipass Opticare Vision Plan Preferred Vision Care
 Spectera / Optum Health VBA VSP Other _____

Primary Care Doctor and Phone Number

CURRENT HEALTH HISTORY

When was your last physical exam? _____ Physician's Name _____

How would you describe your general health: Excellent Average Poor

List all medications (prescription or non-prescription)

Do you have any allergies or are you allergic to any medications? Yes No

List them if yes _____

Have you had any operations? Yes No Kind? _____ When? _____

Since we have seen you last please check all that apply medically:

High Blood Pressure Low Blood Pressure Thyroid Problems Cancer Diabetes
 Hypoglycemia Epilepsy or Convulsions Heart Problems Sexually Transmitted Disease

Other health problems: _____

Female patients, if you are currently taking oral contraceptives or hormonal supplements, please indicate length of Rx history: _____

If you are pregnant, please indicate how many months: _____

PERSONAL EYE INFORMATION

What Specific Problems are you having with your eyes? Please Explain:

Have you had any Eye Injuries or Eye Operations since we last saw you? Please Explain:

Since we have seen you last please check all that apply personally to your eye health:

Cataracts Eye Disease Blindness Glaucoma Macular Degeneration Dry Eyes
 Retinal Detachment Vitreous Detachment Other: _____

Are you currently using a computer? Yes No How many hours per day? _____ Do you

still have the same glasses you purchased from us? Yes No If No, where and when did you get

them? _____

(OVER)

Are you planning to get new glasses today? () Yes () No – Only if Rx changes

Are you planning to get new contacts today? () Yes () No – Only if Rx changes

Are you interested in finding out more about laser vision correction? () Yes () No () Maybe

CONTACT LENS WEARERS

Are you presently wearing the same contacts? () Yes () No If No, what type are you wearing and where and when did you get them? _____

What current solutions are you using? _____

Do you currently use any drops or medication for your eyes? () Yes () No If so, please list: _____

I authorize the release of any medical or other information necessary to process any claims arising from services and materials provided. I also request payment of government or private insurance benefits to the physician accepting assignment for services and materials provided. I also understand that I assume all financial responsibility for this account for any amounts due, regardless of insurance coverage.

Signature

Date

Relationship to Patient

