CONTEMPORARY EYE CARE

WELCOME TO OUR OFFICE!

Today's Date:

Patient Information

Last _____

First _____ MI _____

Date of Birth _____ Age _____

Sex M F

Street _____

City _____ State _____

Zip Code _____

Home Phone _____

Work Phone _____

Cell Phone _____

Email Address _____

How do you prefer to be contacted (circle)?

Home Work Cell Text Email

Patient's SSN _____

Employer _____

Occupation _____

Spouse _____

Emergency Contact _____

NEW PATIENTS ONLY:

Who may we thank for referring you to our office?

_____

If not referred, how did you choose our office?

❑ Referred from another Dr:_____

❑ Insurance List

❑ Sign/Building

❑ Social Media (Facebook, Instagram, LinkedIn)

❑ Website

❑ Other _____

Insurance Information

Vision Insurance_____

Subscriber Name_____

Subscriber ID or SSN_____

Subscriber Date of Birth_____

Medical Insurance_____

Subscriber Name_____

Subscriber ID or SSN_____

Subscriber Birth Date_____

Patient Eye History

Date of Last Eye Exam_____

Doctor or Clinic:_____

Do you currently wear glasses? ❑ Yes ❑ No

Do you currently wear contact lenses? ❑ Yes ❑ No

What design? ❑ Dailies ❑ Monthly ❑ 2-week
❑ Annual replacement ❑ RGP ❑ Scleral lens
❑ Other

Solutions used_____

If not, are you interested in contact lenses? ❑ Yes ❑ No

What is one thing you like about your glasses/contact lenses?

_____

What is one thing you would change about your glasses/contact lenses?

_____

Have you ever experienced, been diagnosed or treated for any of the following?

❑ Blurry Vision
❑ Burning
❑ Cataracts
❑ Corneal Abrasions
❑ Crossed eye/Eye turn
❑ Double Vision
❑ Eye Infections
❑ Eye Injury
❑ Flash of light
❑ Floaters/Spots
❑ Glaucoma
❑ Grittiness
❑ Headaches
❑ Iritis/Uveitis
❑ Itchiness
❑ Lazy Eye
❑ Macular Degeneration
❑ Occasional dryness
❑ Retinal Detachment
❑ Sunlight Sensitivity
❑ Tearing
❑ Trouble seeing at night
❑ Uncomfortable glasses
❑ Keratoconus
❑ Corneal disorder
❑ Corneal dystrophy
❑ Other eye conditions:_____

<u>Eye Surgeries</u>

❑ Lasik
❑ RK
❑ PRK
❑ SMILE
❑ Corneal transplant
❑ Other_____

How many hours are you on the computer and/or electronic devices? _____

Patient Medical History

Name of Primary Care Physician_____
City_____
Phone #_____
Date of Last Physical Check-up_____

CURRENT MEDICATIONS (Rx or Over the Counter)
(List name of medications including eye drops, vitamins, & birth control pills)_____

_____

_____

_____

Allergies to medications? ❑ Yes ❑ No
If so, what medications?_____

Have you had any surgeries? ❑ Yes ❑ No

_____

Do you use cigarettes/tobacco? ❑ Yes ❑ No
(Circle): Everyday Occasionally Socially

Do you use other substances? ❑ Yes ❑ No

Do you drink alcohol? ❑ Yes ❑ No
(Circle): Everyday Occasionally Socially

Have you ever been diagnosed or treated for the following health problems?	**Yes**	**No**
Allergies	❑	❑
Arthritis	❑	❑
Blood/Lymph	❑	❑
Bronchitis	❑	❑
Cancer	❑	❑
Cholesterol	❑	❑
Diabetes	❑	❑
Digestive	❑	❑
Ears/Nose/Throat	❑	❑
Endocrine	❑	❑
Eczema/Rashes	❑	❑
Fatigue	❑	❑
Fevers	❑	❑
Genitourinary	❑	❑
High Blood Pressure	❑	❑
Integumentary (Skin)	❑	❑
Kidney	❑	❑
Muscle/Bone	❑	❑
Neurological	❑	❑
Psychological	❑	❑
Respiratory	❑	❑
Sinus	❑	❑
Throat Infections	❑	❑
Thyroid	❑	❑
Unusual weight losses/gain	❑	❑

Family Medical/Eye History

Is there a family medical history of any of the following:
❑ No ❑ Yes (Please check boxes)

	Relationship (e.g. mother, father, grandparent, sibling)
Eye Conditions	
Glaucoma	❑_____
Cataracts	❑_____
Macular Degeneration	❑_____
Retinal Problems	❑_____
Strabismus (lazy eye)	❑_____
Blindness	❑_____
Keratoconus	❑_____
Corneal transplant	❑_____
Medical Conditions	
Diabetes	❑_____
Hypertension	❑_____
High Cholesterol	❑_____
Thyroid	❑_____
Cardiovascular	❑_____
Other	❑_____

Please be advised if you are using insurance coverage for today's visit, this is a contract between you and your insurance company, not Contemporary Eye Care.

If your insurance company has not reimbursed our office in full within 90 days, you may be responsible for providing payment in full to Contemporary Eye Care.