Welcome to . Thank you for choosing us for your eye care needs. We are delighted to have you as a patient and appreciate the confidence you placed in us. Please take a moment to complete the following information.

☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms. ☐ Male ☐ Female

First Name MI Last Name Preferred Name

Street Address City State Zip

Social Security Number Date of Birth Cell Phone - Include Area Code Day Phone

Email Address Guardian Person Responsible for Account

PRIMARY INSURANCE INFORMATION (VISION INSURANCE)

Name and Address of Primary Insurance Company City State Zip

M ☐ F ☐

Insured's First Name MI Insured's Last Name

Insured's Identification Number Group Number Insured's Date of Birth

Patient Relationship to Insured

☐ Self ☐ Spouse ☐ Child ☐ Other

Patient Status ☐ Single ☐ Married ☐ Other

☐ Full Time Student ☐ Part Time Student ☐ Employed

SECONDARY INSURANCE INFORMATION (MEDICAL INSURANCE)

Name and Address of Secondary Insurance Company City State Zip

M ☐ F ☐

Insured's First Name MI Insured's Last Name

Insured's Identification Number Group Number Insured's Date of Birth

Patient Relationship to Insured

☐ Self ☐ Spouse ☐ Child ☐ Other

Please Read:

In order to control the cost of billing, we ask that the patient's portion is paid at the time services are rendered unless other arrangements are made in advance. We would rather control billing costs than be forced to raise our fees. All professional services and materials are charged to the patient. The undersigned will ultimately be responsible for any bills incurred in this office regardless of insurance. Accounts 90 days old are subject to collection fees. There will be a service charge on all returned checks.

Payment from my insurance is to be paid directly to Excel Vision. I understand that my Vision Insurance will be billed as my primary insurance. I understand that billing any secondary insurance is my responsibility. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed.

Signature Date

Name

PATIENT INFORMATION

Race

- ☐ American Indian Or Alaska Native
- ☐ Asian
- ☐ Black Or African American
- ☐ Native Hawaiian Or Other Pacific Islander
- ☐ Other Race
- ☐ White
- ☐ Native American
- ☐ Caucasian
- ☐ Refuse To Specify
- ☐ Not Disclosed

Other Race ____________

Ethnicity ◯ Hispanic Or Latino ◯ Not Hispanic Or Latino ◯ Unknown

Preferred Language ◯ English ◯ Spanish ◯ French ◯ Italian ◯ Russian ◯ Portuguese

Height ft ____ in ____ cm/m ____ ◯ ft in ◯ cm ◯ m **Weight** ____ ◯ lbs ◯ kg

Emergency Contact ______________________ Emergency Phone ______________________

How were you referred to our office? ______________________

Do you use Facebook ☐ or Yelp☐ ?

We send text messages and e-mails for appointment reminders. Please opt-out if this is an unwanted service

PRIMARY CARE PHYSICIAN

Primary Care Physician and Clinic Name ______________________

Address of Primary Care Physician ______ City ______ State ______ Zip ______ Phone ______

REFERRING PHYSICIAN

Referring Physician and Clinic Name ______________________

Address of Referring Physician ______ City ______ State ______ Zip ______ Phone ______

Name

PATIENT HISTORY

HEALTH HISTORY

What is the main reason for today's exam ? ______________________

Past Surgeries: ______________________ ______________________

Major Illnesses & Injuries: ______________________ ______________________

Medicines that cause reactions or sensitivities: ______________________

Specific Allergies: ______________________

Current Medications: ______________________ ______________________

______________________ ______________________

Current Eye Drops: ____________ ____________ ____________ ____________

Current Health Problems: ______________________

EYE HISTORY

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
Amblyopia (Lazy Eye)	◯ Yes	◯ No	Glare Sensitivity	◯ Yes	◯ No	Blurred Vision Distance	◯ Yes	◯ No
Blepharitis/Eyelid Irritation	◯ Yes	◯ No	Headaches	◯ Yes	◯ No	Blurred Vision Near	◯ Yes	◯ No
Blindness	◯ Yes	◯ No	Light Sensitivity	◯ Yes	◯ No	Distorted Vision (halos)	◯ Yes	◯ No
Cataract	◯ Yes	◯ No	Tired Eyes	◯ Yes	◯ No	Double Vision	◯ Yes	◯ No
Color Blindness	◯ Yes	◯ No	Burning	◯ Yes	◯ No	Flashes of lights	◯ Yes	◯ No
Diabetic Retinopathy	◯ Yes	◯ No	Dryness	◯ Yes	◯ No	Floaters or Spots	◯ Yes	◯ No
Dry Eye Syndrome	◯ Yes	◯ No	Excess Tearing/Watering	◯ Yes	◯ No	Fluctuating Vision	◯ Yes	◯ No
Eye Injuries	◯ Yes	◯ No	Eyelid Swelling	◯ Yes	◯ No	Loss of Central Vision	◯ Yes	◯ No
Glaucoma	◯ Yes	◯ No	Eye Pain or Soreness	◯ Yes	◯ No	Loss of Side Vision	◯ Yes	◯ No
Glaucoma Suspect	◯ Yes	◯ No	Foreign Body Sensation	◯ Yes	◯ No	Loss of Vision	◯ Yes	◯ No
High Risk Medication	◯ Yes	◯ No	Infection of Eye or Lid	◯ Yes	◯ No	Other	◯ Yes	◯ No
Macular Degeneration	◯ Yes	◯ No	Itching	◯ Yes	◯ No			
PeripheralVascularDisease	◯ Yes	◯ No	Mucous Discharge	◯ Yes	◯ No			
Retinal Detachment	◯ Yes	◯ No	Drooping Eyelid	◯ Yes	◯ No			
Strabismus (Crossed Eyes)	◯ Yes	◯ No	Redness	◯ Yes	◯ No			
Other	◯ Yes	◯ No	Sandy or Gritty Feeling	◯ Yes	◯ No			

GENERAL HEALTH CONDITION

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
Fever/ Weight Loss	◯ Yes	◯ No	Respiratory (Asthma)	◯ Yes	◯ No	Anxiety or Depression	◯ Yes	◯ No
Ears,Nose,Throat	◯ Yes	◯ No	Gastrointestinal	◯ Yes	◯ No	Thyroid, Diabetes	◯ Yes	◯ No
Cardiovascular (high blood pressure etc.)	◯ Yes	◯ No	Kidney, Bladder	◯ Yes	◯ No	Blood/Lymph	◯ Yes	◯ No
			Muscles,Bones,Joints	◯ Yes	◯ No	Allergies	◯ Yes	◯ No
			Skin (rash, skin cancer)	◯ Yes	◯ No	Are you?	☐ Pregnant	
			Neurological (Multiple Sclerosis)	◯ Yes	◯ No		☐ Nursing	

FAMILY HISTORY

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
Amblyopia (Lazy Eye)	◯ Yes	◯ No	Macular Degeneration	◯ Yes	◯ No	Heart Disease	◯ Yes	◯ No
Blindness	◯ Yes	◯ No	Retinal Detachment	◯ Yes	◯ No	High Blood Pressure	◯ Yes	◯ No
Cataract(s)	◯ Yes	◯ No	Strabismus (Eye Turn)	◯ Yes	◯ No	Kidney Disease	◯ Yes	◯ No
Color Blindness	◯ Yes	◯ No	Other Eye Conditions	◯ Yes	◯ No	Lupus	◯ Yes	◯ No
Eye Tumors	◯ Yes	◯ No	Arthritis	◯ Yes	◯ No	Stroke	◯ Yes	◯ No
Glaucoma	◯ Yes	◯ No	Cancer	◯ Yes	◯ No	Thyroid Disease	◯ Yes	◯ No
Glaucoma Suspect	◯ Yes	◯ No	Diabetes	◯ Yes	◯ No	Other Diseases	◯ Yes	◯ No

Name

MEDICAL HISTORY QUESTIONAIRE

SOCIAL HISTORY

Current Occupation : ______________________ Years ________ Employer __________________________

Do you drink alcohol ? If yes, how much/often : ○ No ○ Occasional ○ 1 Per Day ○ 2-3/day ○ 4+/day

Do you smoke ? If yes, how much/often : ○ No ○ Occasional ○ 1/2 pack/day ○ 1 pack/day ○ 1+ pack

Past Smoker? ○ Yes ○ No When did you quit smoking? __________ Smoking Status ____________________

Tobacco use counseling? ○ Yes ○ No Tobacco cessation pharmacological therapy? ○ Yes ○ No

Do you chew tobacco? ○ Yes ○ No Do you use nutritional supplements (vitamins etc.)? ○ Yes ○ No

Do you use Illegal Drugs : ○ Yes ○ No Do you engage in regular exercise? ○ Yes ○ No

SPECTACLE LENS HISTORY

Do you use a computer? ○ Yes ○ No How many hours/day? ______ Distance from Computer? ______

Do you drive? ○ Yes ○ No Daily Mileage _____ Do you have visual difficulty when driving? ○ Yes ○ No

Do you have glare problems? ○ Yes ○ No Do you have problems with night vision? ○ Yes ○ No

Do you currently wear glasses ? ○ Yes ○ No Since ____________

Type of glasses ☐ FullTime ☐ PartTime ☐ Distance ☐ Close

Glasses Owned ☐ SingleVision ☐ Bifocals ☐ Trifocals ☐ Backup ☐ Safety ☐ Sports ☐ Progressive

Have you had trouble in the past with glasses? ○ Yes ○ No ______________________________

Do you wear sunglasses? ○ Yes ○ No Are your sun glasses your current prescription ? ○ Yes ○ No

SPECIAL EYEWEAR NEEDS

☐ Computer (special prescriptions, special anti-glare tints or coatings)
☐ Occupational (mechanics, plumbers, pilots)
☐ Safety Glasses (gardening, woodworking, welding)
☐ Sports/Hobbies (racquet sports, motorcycle)

Hobbies/ Interests : ____

CONTACT LENS HISTORY

Have you ever tried to wear contact lenses? ○ Yes ○ No Reason for stopping? ____________________

If not a contact lens wearer, are you interested in trying contact lenses at this time ? ○ Yes ○ No

Do you currently wear contact lenses? ○ Yes ○ No Since ______________________________

Type and brand of contact lenses ______________________________

How many hours/day ? __________ How many days/week ? ________ Today's wearing time ? _______

What Solutions do you use? Cleaner ______________ Disinfectant __________ Enzyme __________

Please rate the following on a scale of 1-10, with 1 being POOR to 10 being EXCELLENT

	Right	Left		Right	Left		Right	Left
Lens Comfort	_____	_____	Distance Vision	_____	_____	Near Vision	_____	_____