WELCOME TO ADVANTAGE EYECARE!

Patient Information

Today's Date_____
Last_____
First_____ MI_____
Date of Birth _____ Age_____
Sex: M F
Street_____
City_____ State_____
Zip Code_____
Cell Phone_____
Home Phone_____
Work Phone_____
Patient's SSN_____
Employer (or School)_____
Occupation (or Grade)_____
Race_____
Language_____
Spouse (or Parent's Name)_____
Spouse (or Parent's Work)_____
Email Address_____
(For Advantage Eyecare use only)

What is the major purpose of your visit?

_____

Are there any problems with your current contact lenses or glasses? If so, please explain.

_____
_____

Insurance Information

Vision Insurance_____
Subscriber Name_____
Subscriber SSN_____
Subscriber Birth Date_____

Primary Medical Insurance_____
Subscriber Name_____
Subscriber ID#_____
Subscriber Birth Date_____

Do you participate in a flex spending account?
❑ Yes ❑ No

How will you settle your account today?
❑ Cash ❑ Check ❑ Credit Card

HIPPA Privacy Rule

Due to the HIPPA Privacy Rule, we ask that you would list the following person or persons to receive your Protected Health Information (PHI) pertaining to your medical care other than yourself, any Doctor, or Staff involved in your care.

Name_____ Relationship_____
Name_____ Relationship_____
Name_____ Relationship_____

Lifestyle Questions

Do you.....(check box if your answer is yes.)

❑..work at a computer?
❑..think you might benefit from thinner, lighter lenses?
❑..have interest in a "test drive" of the latest contact lens designs?
❑..spend time outdoors? How many_____Hrs/week
❑..have prescription sun wear?
❑..prefer not to wear glasses at times?
❑..want information on Laser Vision Correction surgery?
❑..have interest in a non-surgical approach to vision correction?
❑..have children? How many?_____
❑..have family members in need of eyecare?
❑..hobbies? _____

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	

❑ Other Eye Disorders_____

--Advantage Eyecare's Dr.'s and Staff are fully dedicated to excellence.

--We promise you the highest standard of Eye Care providing a lifetime of healthy vision and quality of life.

--This we pledge to each one of our patients. You are our highest priority.

The information in this confidential case history form is critical to the evaluation of your vision and health.

Patient Medical History

Name of Family Physician_____
Town_____
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
< 1 Pack per day? ❑ Yes ❑No

Do you consume alcohol? If so, how much?

_____

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

I acknowledge that the above is true to the best of my knowledge and I received a copy of Advantage EyeCare's Notice of Privacy Practices:
Signature: _____ Date: _____
(Patient/Legal Guardian)

Doctor Signature Date

Patient Eye History

Date of Last Eye Exam_____
By whom?_____

Have you ever tried contact lenses? ❑ Yes ❑ No

Do you currently wear contact lenses? ❑ Yes ❑ No
What kind?_____
Solutions used_____

Are you satisfied with the vision and comfort of your contact lenses? ❑ Yes ❑ No

Would you prefer clear contact lenses or colored contact lenses? ❑ Clear ❑ Colored

If you wear bifocals, do the lines or head tilting bother you? ❑ Yes ❑ No

Family Medical/Eye History (Check all that apply)

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

		Relationship (Mother's or Father's side)
Blindness	❑	_____
Cataracts	❑	_____
Corneal Problems	❑	_____
Diabetes	❑	_____
Glaucoma	❑	_____
Heart Disease	❑	_____
Lazy Eye	❑	_____
Macular Degeneration	❑	_____
Retinal Problems	❑	_____

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

There have been many changes with insurance companies. Upon arrival we will need to see your insurance cards and know the name of your vision plan. Vision plan names are often different than your medical plan name.

If we are not providers for your insurance plan, we will give you the information detailing your charges for the day so that you may send it in for reimbursement. You will be responsible for payment on the day of service.