Loudoun Eye Associates, pLLC

WELCOME TO OUR OFFICE

Name (Last, First, MI): _____ Sex: _____ DOB: _____ Age: _____

Address: _____ City: _____ State: _____ Zip-Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Social Security No.: _____ Occupation: _____ Employer: _____

Email: _____When was your last EYE EXAM? _____

Have you been to our office before? _____ How did you hear about us? _____

Reason for today's visit: _____

Contact Lens Information

Do you wear contacts? _____ If so, what type? _____ Soft _____ Gas Permeable/Hard _____ Astigmatism

How do you wear them? _____ Daily Wear _____ Extended Wear Type of disinfection (Brand)? _____

General Health and Eye History (Note **S** for self and **F** for family member)

___ Cataracts	___ High Blood Pressure	___ Heart Disease /Heart Conditions	___**Interested in LASIK (Laser Surgery)**
___ Glaucoma	___ Diabetes	___ Bleeding Disorders	___**Interested in Contact Lenses**
___ Macular Degeneration	___ High Cholesterol	___ Kidney Conditions	___**I work on computers**
___ Strabismus "Lazy Eye"	___ Neurologic Condition	___ Liver Conditions or Hepatitis	___**I DO NOT wear sunglasses**
___ Retinal Disorders	___ Stroke	___ Urinary Conditions	**Hobbies:**_____
___ Dry Eye	___ Headaches	___ Autoimmune Conditions	_____
___ Corneal Disease	___ Asthma or Breathing Conditions	___ HIV	_____
___ Amblyopia	___ Ear/Nose/Throat Conditions	___ Cancer	**Sports:** _____
___ Eye Surgery	___ Environmental/Seasonal Allergies	___ Other: _____	_____

Please list your current prescription medications, over the counter medications, and eye drops: _____

_____

Are you allergic to any medications? If yes, please list: _____

Are you pregnant? _____ Do you smoke? _____, Packs/day_____ Do you drink alcohol?_____, how often?_____

History of any surgeries? _____Comments or other medical history not listed above: _____

MEDICAL Insurance Information (Not Vision Insurance Information)

Name of Insurance: _____ ID No.: _____ Group No.: _____

Name of Primary Insurance Subscriber: _____ SSN: _____ DOB: _____

Employer: _____ Work Phone: _____ Relationship to patient: _____

Insurance Information Release Authorization

I, _____, hereby authorize Loudoun Eye Associates, pLLC to release or exchange any information necessary to process my insurance claims. I will receive services with the understanding that in the event my coverage is not effective, I will be billed by the service provider and held responsible for services rendered. Furthermore, I understand what my benefits are and that there may be additional charges beyond the coverage benefits. I have reviewed the Notice of Privacy Practices for Loudoun Eye Associates, pLLC, and a copy of the notice has been made available for me at my request.

Patient, Parent or Guardian's Signature: _____ Date: _____