MIDWEST EYE ASSOCIATES

Today's Date _____

PATIENT INFORMATION

Last Name _____
First Name _____
Date of Birth _____ Age _____ Sex M / F
Patient's SSN _____
Street Address _____
City _____ State _____ Zip _____
Home Phone _____
Cell Phone _____
Work Phone _____
Email Address _____
Employer (or School) _____
Occupation (or Grade) _____
Spouse or Parent's Name _____
Spouse or Parent's Work _____
Patient's Race _____
Circle One: Hispanic/Latino Not Hispanic/Latino
Preferred Language _____

What is the major purpose of this visit?
_____
_____

Are you experiencing any problems with your current glasses or contact lenses?
_____
_____

Who may we thank for referring you to our office?
Name of friend or relative _____
If not referred, how did you choose our office?

- Another Dr. _____
- Insurance List
- Saw Sign / Building
- Newspaper / Radio / TV
- Website: Which one? _____
- Other: _____

INSURANCE INFORMATION

Please note that most insurance plans do NOT cover the Contact Lens Evaluation

Vision Insurance _____
Subscriber Name _____
Subscriber SSN _____
Subscriber Birth Date _____

Primary Medical Insurance _____
Subscriber Name _____
Subscriber SSN _____
Subscriber Birth Date _____

Please only complete the following if you are covered by a Secondary Insurance Plan:
Insurance Provider _____
Subscriber Name _____
Subscriber SSN _____
Subscriber Birth Date _____

Do you have a flex spending account? Y / N

LIFESTYLE QUESTIONS

Do you… (check boxes if answer is yes)

- Work at a computer?
- Plan on purchasing new glasses today?
- Think you might benefit from tinner, lighter lenses?
- Spend time outdoors? How much? ___hrs/wk
- Have prescription sunglasses?
- Prefer not to wear your glasses at times?
- Want information on Laser Vision Correction surgery?
- Have more than 1 pair of current Rx eyewear?
- Have children?
- Have family members in need of eyecare?

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

- Blurry Vision
- Cataracts
- Crossed Eye/Eye Turn
- Eye Infections
- Flash of Light
- Glaucoma
- Headaches
- Itchiness
- Macular Degeneration
- Retinal Detachment
- Trouble Seeing at Night
- Burning

- Corneal Abrasion
- Double Vision
- Eye Injury
- Floaters/Spots
- Iritis/Uveitis
- Lazy Eye
- Occasional Dryness
- Sunlight Sensitivity
- Other: _____

PATIENT MEDICAL HISTORY

Name of Family Physician _____
Address _____
Phone _____
Date of Last Visit _____

Additional Physicians you see routinely that you would like us to send your vision visits to:
Doctor _____
Address _____
Phone _____

Preferred Pharmacy _____
Address _____
Phone_____

CURRENT MEDICATIONS
(List all including eye drops and vitamins)
_____
_____
_____

Allergies to Medications
_____
_____

Have you had any surgeries?
_____
_____

Are you currently Pregnant / Nursing? (circle)

Do you:
- Drink Alcohol
- Smoke/Use Tobacco

Have you ever been diagnosed or treated for the following health problems?
- Cancer
- Ears/Nose/Throat
- Neurological
- Psychiatric
- Cardiovascular
- Respiratory
- Gastrointestinal
- Gastrourital
- Muscular/Skeletal
- Integumentary (Skin)
- Endocrine
- Blood/Lymph
- Allergy/Immunology
- Please Explain:
  _____
  _____

PATIENT EYE HISTORY

Date of Last Eye Exam _____
By Whom? _____
Have you ever tried wearing contact lenses? Y / N
Do you currently wear contact lenses? Y / N
What kind? _____
Solution Used _____
If you wear bifocals, do the lines or head tilting bother you? Y / N

FAMILY MEDICAL AND EYE HEALTH HISTORY

Check all that apply and list only IMMEDIATE family members.
- High Blood Pressure _____
- Diabetes Type 1/2 _____
- Cancer _____
- Hyper-/Hypo-thyroidism _____
- Macular Degeneration _____
- Retinal Detachment _____
- Cataracts _____
- Glaucoma _____

HIPAA AND FINANCIAL ACKNOWLEDGMENT

Please be advised if you are using insurance coverage for today's visit, this is a contract between you and your insurance company; not Midwest Eye Associates.
I understand that I am financially responsible for all charges whether or not paid by insurance.
I understand the Notice of Privacy Practices and I have been provided an opportunity to review it.
If you wish to read the Notice of Privacy Practices, it is listed on our website.

Patient Signature _____