

Patient Name _____ Date of Birth _____

Address _____

Home Phone _____ Cell Phone _____ Daytime Phone _____

Email _____ Marital Status _____ Family Dr. _____

If minor, responsible party and their relationship _____

Employer _____ Occupation _____

Do you have any medication allergies? _____

List all medications you are currently taking: _____

What eye surgeries have you had? _____

What other surgeries have you had? _____

When was your last eye examination? _____ Where? _____

List any eye disorders you have: _____

Check all that have affected you recently:

- | | | |
|---|--|---|
| <input type="checkbox"/> Discomfort with your eyes | <input type="checkbox"/> Headaches | <input type="checkbox"/> Dry Eyes |
| <input type="checkbox"/> Problems with glare or reflections | <input type="checkbox"/> Floaters or flashes of light | <input type="checkbox"/> Other Eye Symptoms |
| <input type="checkbox"/> Distance blurry with current glasses | <input type="checkbox"/> Reading blurry with current glasses | |

Are you interested in information about Contact Lenses? YES or NO MAYBE

Are you interested in information about Laser Eye Surgery? YES or NO MAYBE

Do you anticipate getting new glasses today? YES or NO MAYBE

Do you have in Contact Lenses today? YES or NO

List any **family members** and their relationship to you that have:

- | | | |
|------------------------------------|---|--|
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Blindness |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Crossed or lazy eye | <input type="checkbox"/> Other eye disease |

Please mark any of the following conditions which you have had in the past several weeks:

- | | | |
|--|--------------------------------|-------------------|
| Allergy/IMM: Allergies _____ | | |
| Cardio: High Blood Pressure _____ | Stroke _____ | Chest Pains _____ |
| Constitutional: Fever _____ | Feel "sick" _____ | |
| Endocrine: Diabetes _____ | Thyroid disease _____ | |
| Gastro: GI problems or ulcers _____ | | |
| Genito/Urinary: Kidney/Bladder problems _____ | | |
| Head: Headaches _____ | Ear/Nose/Throat Problems _____ | |
| Hema/Lymph: Bleeding problems _____ | | |
| Musculoskel: Swollen joints _____ | | |
| Neuro: Dizziness _____ | | |
| Psych: Psychiatric Problems _____ | | |
| Resp: Breathing Problems _____ | | |

I authorize the release of any medical or other Protected Health Information necessary to process this claim, or provide treatment. I also request payment of government and insurance benefits payable to Lifetime Eyecare Optometry, P.A. I am responsible for the deductible, co-insurance, and all non-covered services. I am responsible for any and all non-covered services related to insufficient or incorrect insurance information provided to Lifetime Eyecare. I acknowledge that I have been afforded the opportunity to review Lifetime Eyecare's Notice of Privacy Practices and have been given a copy if requested.

Signature: _____ Date: _____