

WELCOME TO OUR OFFICE

Date _____

PATIENT INFORMATION

Last _____

First _____ MI _____

Street _____

City _____ State _____

Zip Code _____

Home Phone _____

Work Phone _____

Cell Phone _____

Patient's SSN _____

Employer (or School) _____

Occupation (or Grade) _____

Spouse (or Parent's Name) _____

Spouse (or Parent's Employer) _____

Date of Birth _____ Age _____

Sex M F

Email Address _____

What is the primary purpose of this visit? _____

Any problems with your current contact lenses or glasses? _____

VERY IMPORTANT! NEW PATIENTS ONLY:

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

Yellow Pages: Which directory?

Web Page: Which Web Site?

Other _____

IT IS OUR MISSION to provide only the highest quality visual and ocular health care. We strive to build a caring relationship with every patient through patient education and always keeping the patient's best interest in mind. We do so in an effort to provide expert care over a lifetime.

INSURANCE INFORMATION

Please note that insurance does NOT cover the Contact Lens Follow-Up Evaluation.

Vision Insurance _____

Subscriber Name _____

Subscriber SSN _____

Subscriber Birth Date _____

Primary Medical Insurance _____

Subscriber Name _____

Subscriber SSN _____

Subscriber Birth Date _____

Do you participate in a flex spending account?

Yes No

How will you settle your account today?

Cash Check Credit Card

LIFESTYLE QUESTIONS

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

work at a computer? *If yes, please complete computer questionnaire.*

think you might benefit from thinner, lighter lenses?

have interest in a "test drive" of the latest contact lens designs?

spend time outdoors? How much? _____ Hrs/week

have prescription sunwear?

prefer not to wear your glasses at times?

want information on Laser Vision Correction surgery?

have interest in a non-surgical approach to vision correction?

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

Tearing

Uncomfortable glasses

Other eye disorders _____

Burning

Corneal Abrasions

Double Vision

Eye Injury

Floaters/Spots

Grittiness

Iritis/Uveitis

Lazy Eye

Occasional dryness

Sunlight Sensitivity

Trouble seeing at night

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 _____

Location _____

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, alcohol, or other substances?

Yes No

Have you ever been diagnosed or treated for the following health problems?

	Yes	No
Allergies.....	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis.....	<input type="checkbox"/>	<input type="checkbox"/>
Blood/Lymph.....	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis.....	<input type="checkbox"/>	<input type="checkbox"/>
Cancer.....	<input type="checkbox"/>	<input type="checkbox"/>
Cholesterol.....	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>
Digestive.....	<input type="checkbox"/>	<input type="checkbox"/>
Ears/Nose/Throat.....	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine.....	<input type="checkbox"/>	<input type="checkbox"/>
Eczema/Rashes.....	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue.....	<input type="checkbox"/>	<input type="checkbox"/>
Fevers.....	<input type="checkbox"/>	<input type="checkbox"/>
Genitourinary.....	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure.....	<input type="checkbox"/>	<input type="checkbox"/>
Integumentary (Skin).....	<input type="checkbox"/>	<input type="checkbox"/>
Kidney.....	<input type="checkbox"/>	<input type="checkbox"/>
Muscle/Bone.....	<input type="checkbox"/>	<input type="checkbox"/>
Neurological.....	<input type="checkbox"/>	<input type="checkbox"/>
Psychological.....	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory.....	<input type="checkbox"/>	<input type="checkbox"/>
Sinus.....	<input type="checkbox"/>	<input type="checkbox"/>
Throat Infections.....	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid.....	<input type="checkbox"/>	<input type="checkbox"/>
Unusual weight losses/gains.....	<input type="checkbox"/>	<input type="checkbox"/>

Have you ever been infected with:

Gonorrhea Hepatitis HIV Syphilis

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 or progressives, 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	<input type="checkbox"/> _____
Cataracts	<input type="checkbox"/> _____
Corneal Problems	<input type="checkbox"/> _____
Diabetes	<input type="checkbox"/> _____
Glaucoma	<input type="checkbox"/> _____
Heart Disease	<input type="checkbox"/> _____
Lazy Eye	<input type="checkbox"/> _____
Macular Degeneration	<input type="checkbox"/> _____
Retinal Problems	<input type="checkbox"/> _____

Please be advised if you are using insurance coverage for today's visit, this is a contract between you and your insurance company... not Andrea M. Barnhart, O.D.

If your insurance company has not reimbursed our office in full within 90 days, your credit card will be utilized and your insurance company will then pay you directly. (If by mistake your insurance company sends the payment check to us, we will of course sign over and forward the check directly to you.)

Please enter your credit card number and expiration date.

CC#: _____

Expiration Date: _____

Signature _____