

Welcome to Our Office

Name _____

First Middle Last

Street _____

City _____ State _____ Zip _____

PO box _____

Phone: Home _____ Cell _____

Work _____

Social security number _____

Employer/School _____

Occupation _____

Email Address _____

Insurance Information

(must be completed to file any claims)

Vision Plan _____ Medical Ins. _____

Name of Insured _____

Insured's Employer _____

Insured's Date of Birth _____

Insured's SS# _____

Pt.'s relationship to insured: Self Spouse Child Other

Pt.'s marital status: Single Married Widowed Divorced

How did you hear about our office? _____

Privacy Practices & Financial Responsibility

I acknowledge that a copy of Professional Eye Care's Notice of Privacy Practices has been made available to me. I agree to be responsible for any fees incurred as a result of my insurance company's failure to pay for all services and/or materials provided. This includes reasonable collection fees.

Signature: _____ Date: _____

(Please circle one: Patient or Guardian)

Retinal Photography Policy

Retinal photography provides specialized documentation of eye health for future reference, and in most cases, helps the patient to avoid the inconvenience of Pupil Dilation.

Retinal photography is an enhanced level of service that is not covered by routine vision plans; however, the doctors of PEC recommend digital retinal photography for all their patients.

Yes, I prefer to have Retinal Photography as part of my routine eye exam. I understand that this is not covered by my vision or medical plan, and I will pay \$25 for the enhanced level of service. I understand that if I have a medical condition that requires retinal photography, I will not pay the \$25 fee today, and a \$79 fee will be billed to my major medical plan.

NO, I choose not to have Retinal Photography of my eyes today as part of my eye exam. I understand the doctor will use drops to dilate my pupils instead.

Signature: _____ Date: _____

Today's date _____ Date of last exam _____

Date of birth _____ Age _____ Sex: M F

Family Medical History: Do Family Members Have?

Diabetes	Yes	No	Cataract	Yes	No
Ocular Tumors	Yes	No	Glaucoma	Yes	No
Blindness	Yes	No			
Macular Degeneration			Yes	No	
High Blood Pressure			Yes	No	
Retinal Detachment			Yes	No	

Personal Medical History: Do you have?

Allergies	Yes	No	Eye Disorder(s)	Yes	No
Arthritis	Yes	No	Fibromyalgia	Yes	No
Asthma	Yes	No	Heart Disease	Yes	No
Cancer	Yes	No	High Blood Pressure	Yes	No
Depression	Yes	No	Migraines	Yes	No
Digestive Disorder	Yes	No	Neurologic Disorder	Yes	No
Diabetes	Yes	No	Skin Disorder	Yes	No

Current Medications (Rx & Over the Counter)

Name Of Medication Reason For Taking

Name Of Medication	Reason For Taking

Oral Contraceptive Yes No Eye Drops Yes No

List any medications you are allergic to: _____

Name of Family Doctor: _____

Please list any complaints about wearing glasses or contacts

Do you have more than 1 pair of glasses?	Yes	No
Do you work on a computer for long periods of time?	Yes	No
Are you interested in thinner, lighter weight lenses?	Yes	No
Do you spend a lot of time outdoors?	Yes	No
Do you have difficulty driving at night?	Yes	No
Are you interested in wearing contact lenses?	Yes	No
If you wear contacts, are you satisfied with the vision and comfort?	Yes	No
Are you interested in trying the newest contact lens design(s)?	Yes	No
If you currently wear bifocals, are you interested in learning about the latest no-line designs?	Yes	No
Would you like to learn about laser vision correction?	Yes	No

Do You Experience...

Any discomfort with your eyes?	Yes	No
Problems with glare or reflections?	Yes	No
Sensitivity to light?	Yes	No
Headaches?	Yes	No
Floater or flashes of light?	Yes	No
Double vision?	Yes	No