

Welcome to . Thank you for choosing us for your eyecare needs. We are delighted to have you as a patient and appreciate the confidence you placed in us. Please take a moment to complete the following information. Any information we already have on file will appear on this form. Please review all completed areas to ensure that the information we have is current and accurate. If you have any questions, please do not hesitate to ask.

Mr. Miss Mrs. Ms. Male Female

First Name MI Last Name Preferred Name

Street Address City State Zip

Social Security Number Date of Birth Home Phone - Include Area Code Work Phone

Email Address Spouse or Parent(s) Name Person Responsible for Account

Primary Care physician: _____ **Emergency Contact** _____

How were you referred to our office?
 Advertisement Doctor (Please Name) _____ **Emergency Phone** _____
 School Patient (Please Name) _____
 Phone Book Other _____ Drive by Insurance Listing

PRIMARY INSURANCE INFORMATION

Name and Address of Primary Insurance Company City State Zip

M F _____
Insured's First Name MI Insured's Last Name

Insured's Identification Number Group Number Insured's Date of Birth
Patient Relationship to Insured **Patient Status** Single Married Other
 Self Spouse Child Other Full Time Student Part Time Student Employed

SECONDARY INSURANCE INFORMATION

Name and Address of Secondary Insurance Company City State Zip

M F _____
Insured's First Name MI Insured's Last Name

Insured's Identification Number Group Number Insured's Date of Birth Self Spouse Child Other
Patient Relationship to Insured

Please Read:

In order to control the cost of billing, we ask that the patient's portion is paid at the time services are rendered unless other arrangements are made in advance. We would rather control billing costs than be forced to raise our fees. All professional services and material are charged to the patient. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Accounts 90 days old are subject to collection fees. There will be a service charge on all returned checks.

Payment from my insurance is to be paid directly to . I understand that will be billed as my primary insurance. I understand that billing any secondary insurance is my responsibility. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed.

Signature Date 4

Name _____
Date _____

Allegan Eyecare
MEDICAL HISTORY QUESTIONNAIRE

EYE HISTORY

- | | | | | | |
|-------------------------|---------------------------|--------------------------|--------------------------|---------------------------|--------------------------|
| Headaches | <input type="radio"/> Yes | <input type="radio"/> No | Blurred Vision Distance | <input type="radio"/> Yes | <input type="radio"/> No |
| Glare/Light Sensitivity | <input type="radio"/> Yes | <input type="radio"/> No | Blurred Vision Near | <input type="radio"/> Yes | <input type="radio"/> No |
| Tired Eyes | <input type="radio"/> Yes | <input type="radio"/> No | Distorted Vision (halos) | <input type="radio"/> Yes | <input type="radio"/> No |
| Lazy Eye | <input type="radio"/> Yes | <input type="radio"/> No | Double Vision | <input type="radio"/> Yes | <input type="radio"/> No |
| Burning | <input type="radio"/> Yes | <input type="radio"/> No | Floaters or Spots | <input type="radio"/> Yes | <input type="radio"/> No |
| Dryness | <input type="radio"/> Yes | <input type="radio"/> No | Fluctuating Vision | <input type="radio"/> Yes | <input type="radio"/> No |
| Excess Tearing/Watering | <input type="radio"/> Yes | <input type="radio"/> No | Loss of Vision | <input type="radio"/> Yes | <input type="radio"/> No |
| Eye Pain or Soreness | <input type="radio"/> Yes | <input type="radio"/> No | Loss of Side Vision | <input type="radio"/> Yes | <input type="radio"/> No |
| Foreign Body Sensation | <input type="radio"/> Yes | <input type="radio"/> No | Drooping Eyelid | <input type="radio"/> Yes | <input type="radio"/> No |
| Infection of Eye or Lid | <input type="radio"/> Yes | <input type="radio"/> No | Redness | <input type="radio"/> Yes | <input type="radio"/> No |
| Itching | <input type="radio"/> Yes | <input type="radio"/> No | Sandy or Gritty Feeling | <input type="radio"/> Yes | <input type="radio"/> No |
| Mucous Discharge | <input type="radio"/> Yes | <input type="radio"/> No | Crossed Eyes | <input type="radio"/> Yes | <input type="radio"/> No |

GENERAL HEALTH CONDITION

- | | | | | | |
|------------------------|---------------------------|--------------------------|-------------------------------|---------------------------|--------------------------|
| Fever | <input type="radio"/> Yes | <input type="radio"/> No | Kidney | <input type="radio"/> Yes | <input type="radio"/> No |
| Weight Loss | <input type="radio"/> Yes | <input type="radio"/> No | Muscles, Bones, Joints | <input type="radio"/> Yes | <input type="radio"/> No |
| Other Consti. Symptoms | <input type="radio"/> Yes | <input type="radio"/> No | Skin | <input type="radio"/> Yes | <input type="radio"/> No |
| Ears, Nose, Throat | <input type="radio"/> Yes | <input type="radio"/> No | Neurological (MS) | <input type="radio"/> Yes | <input type="radio"/> No |
| high blood pressure | <input type="radio"/> Yes | <input type="radio"/> No | Anxiety, Depression, Insomnia | <input type="radio"/> Yes | <input type="radio"/> No |
| Respiratory (Asthma) | <input type="radio"/> Yes | <input type="radio"/> No | Diabetes, thyroid | <input type="radio"/> Yes | <input type="radio"/> No |
| Gastrointestinal | <input type="radio"/> Yes | <input type="radio"/> No | Blood/Lymph (cholesterol) | <input type="radio"/> Yes | <input type="radio"/> No |
| | | | Allergic/Immunologic | <input type="radio"/> Yes | <input type="radio"/> No |

Past Illnesses or Injuries: _____

Past Surgeries: _____

Current Medications: _____

Medicines that cause reactions or sensitivities: _____

Specific Allergies: _____

FAMILY HISTORY

- | | | | | | |
|----------------------|---------------------------|--------------------------|---------------------|---------------------------|--------------------------|
| Lazy Eye | <input type="radio"/> Yes | <input type="radio"/> No | Arthritis | <input type="radio"/> Yes | <input type="radio"/> No |
| Blindness | <input type="radio"/> Yes | <input type="radio"/> No | Cancer | <input type="radio"/> Yes | <input type="radio"/> No |
| Cataract(s) | <input type="radio"/> Yes | <input type="radio"/> No | Diabetes | <input type="radio"/> Yes | <input type="radio"/> No |
| Color Blindness | <input type="radio"/> Yes | <input type="radio"/> No | Heart Disease | <input type="radio"/> Yes | <input type="radio"/> No |
| Glaucoma | <input type="radio"/> Yes | <input type="radio"/> No | High Blood Pressure | <input type="radio"/> Yes | <input type="radio"/> No |
| Macular Degeneration | <input type="radio"/> Yes | <input type="radio"/> No | Kidney Disease | <input type="radio"/> Yes | <input type="radio"/> No |
| Retinal Detachment | <input type="radio"/> Yes | <input type="radio"/> No | Lupus | <input type="radio"/> Yes | <input type="radio"/> No |
| Eye Turn | <input type="radio"/> Yes | <input type="radio"/> No | Stroke | <input type="radio"/> Yes | <input type="radio"/> No |
| | | | Thyroid Disease | <input type="radio"/> Yes | <input type="radio"/> No |
| | | | Others | <input type="radio"/> Yes | <input type="radio"/> No |

Name _____

Allegan Eyecare

Date _____

PATIENT HISTORY AND INFORMATION

VISUAL HISTORY

Current Occupation _____ Years _____ Employer _____

Do you use a computer? Yes No How many hours/day _____ Distance from Computer _____

Do you drive? Yes No Mileage to work each way _____ Do you have glare problems? Yes No

Do you have visual difficulty when driving? Yes No

Do you have problems with night vision? Yes No

SPECTACLE LENS HISTORY

Do you currently wear glasses? Yes No Since _____

Type of glasses Full Time Part Time Distance Close

Glasses Owned

Single Vision Bifocals Trifocals Back-up Glasses Safety Glasses Sports Glasses Progressive

Have you had trouble in the past with glasses? Yes No _____

Do you wear sunglasses? Yes No Are your sun glasses your current prescription? Yes No

CONTACT LENS HISTORY

Have you ever tried to wear contact lenses? Yes No Reason for stopping _____

Do you currently wear contact lenses? Yes No Since _____

If not a contact lens wearer, are you interested in trying contact lenses at this time? Yes No

Type and brand of contact lenses _____ Today's wearing time? _____

How many hours/day? _____ How many days/week? _____

Please rate the following on a scale of 1-10, with 1 being POOR to 10 being EXCELLENT

	Right	Left		Right	Left		Right	Left
Lens Comfort :	_____	_____	Distance Vision :	_____	_____	Near Vision :	_____	_____

What Solutions do you use? Cleaner _____ Disinfectant _____ Enzyme _____

SOCIAL HISTORY

Do you use nutritional supplements (vitamins etc.)? Yes No

Do you engage in regular exercise? Yes No

Do you drink alcohol? If yes, how much/often : No Occasional 1 per day 2-3/day 4+/day

Do you smoke? If yes, how much/often : No Occasional 1/2 pack/day 1 pack/day 1+ pack

Hobbies/ Interests : _____

SPECIAL EYEWEAR NEEDS

- | | |
|---|---|
| <input type="checkbox"/> Computer (special prescriptions, special anti-glare tints or coatings) | <input type="checkbox"/> Safety Glasses (gardening, woodworking, welding) |
| <input type="checkbox"/> Occupational (mechanics, plumbers, pilots) | <input type="checkbox"/> Sports/Hobbies (racquet sports, motorcycle) |

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URGENT (MEDICAL) CARE QUESTIONNAIRE

Name _____ Date _____

Birthdate _____

Reason for your visit today?

List Medications you are taking:

List Allergies to medicines:

Which eye? Right / Left / Both; when did this start? _____

Are your symptoms: Better Worse Same ?

Is the problem continuous or does it come and go?

Is there any discharge from eye? Yes / No

Circle type: watery white stringy yellowish greenish bloody

Is there itching? Yes / No

Are eyes stuck shut in A.M.? Yes / No

Are you more sensitive to light? Yes / No

Do you have flashes of light, spots floating in vision, or veil blocking. Yes / No

If yes: are they stable or getting worse or are they new?

Have you put any drops into eyes? Yes / No What drops? _____

Have you been working near chemicals, welding, grinding, wood chips, insects? Yes / No

Do you wear contact lenses? Yes / No

When did you last wear them? _____ How old are they? _____

Has something similar to this happened before? Yes / No

The minimal charge will be \$45.00, but may vary depending on length of visit or if further testing or treatment is necessary. As part of our services, we are happy to submit this claim to your medical insurance for reimbursement. To avoid any misunderstanding, please read the following:

1. To keep the cost of records and collections down, any payment due will be collected at the time of service.
2. The legal obligation of your insurance provider is between yourself and your provider, not between Allegan Eyecare and your provider
3. Your insurance provider will settle your claim and you will receive payment directly from your insurance company to reimburse you all or part of the amount paid to Allegan Eyecare.

Signature: _____ Date _____