

# FirstView Eye Care Associates

Welcome To Our Office

Today's Date \_\_\_\_\_

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_ Gender: M F  
*Last First MI*

Address \_\_\_\_\_ Marital Status: Single Married Divorced/Separated  
\_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

E-mail Address \_\_\_\_\_

Patient's Employer/School \_\_\_\_\_ Occupation/Grade \_\_\_\_\_

## Spouse Information

Spouse's Name \_\_\_\_\_ Spouse's DOB \_\_\_\_\_

Spouse's Employer \_\_\_\_\_ Spouse's Work # \_\_\_\_\_

## Minor Information

Parent/Guardian Name \_\_\_\_\_

Parent/Guardian Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Parent/Guardian Employer \_\_\_\_\_

## Primary Insured Information

Insured's Name \_\_\_\_\_ DOB \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Primary Insurance \_\_\_\_\_ ID# \_\_\_\_\_

Secondary Insurance \_\_\_\_\_ ID# \_\_\_\_\_

Is there anyone we can thank for referring you to our office? \_\_\_\_\_

## Assignment and Release

I certify that I and/or my dependents have insurance coverage with \_\_\_\_\_ and assign  
name of insurance company

directly to Firstview Eye Care Associates all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

FirstView Eye Care Associates may use my health care information and may disclose such information to the above named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services

\_\_\_\_\_  
Signature of Patient/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Patient/Guardian

\_\_\_\_\_  
Relationship to Patient

## Patient Medical History

Primary Care Physician \_\_\_\_\_

Date of Last Physical Exam \_\_\_\_\_

Current Medications

Medication Allergies

Yes No

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Review of Systems

<b>Allergic/Immunologic</b> Negative____ <input type="checkbox"/> Environmental <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Lupus <input type="checkbox"/> Other	<b>Endocrine</b> Negative____ <input type="checkbox"/> Type I Diabetes <input type="checkbox"/> Type II Diabetes <input type="checkbox"/> Thyroid Dysfunction <input type="checkbox"/> Other	<b>Integumentary</b> Negative____ <input type="checkbox"/> Eczema <input type="checkbox"/> Psoriasis <input type="checkbox"/> Rosacea <input type="checkbox"/> Other	<b>Psychiatric</b> Negative____ <input type="checkbox"/> Depression <input type="checkbox"/> Panic Disorder <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Other
<b>Cardiovascular</b> Negative____ <input type="checkbox"/> Heart Disease <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Stroke <input type="checkbox"/> Vascular Disease <input type="checkbox"/> Other	<b>GI</b> Negative____ <input type="checkbox"/> Crohn's Disease <input type="checkbox"/> Colitis <input type="checkbox"/> Ulcer <input type="checkbox"/> Other	<b>Musculoskeletal</b> Negative____ <input type="checkbox"/> Ankylosing Spondylitis <input type="checkbox"/> Arthritis <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Other	<b>Respiratory</b> Negative____ <input type="checkbox"/> Cigarette Smoker <input type="checkbox"/> Asthma <input type="checkbox"/> Bronchitis <input type="checkbox"/> Emphysema <input type="checkbox"/> Other
<b>Constitutional</b> Negative____ <input type="checkbox"/> Weight Loss <input type="checkbox"/> Fever <input type="checkbox"/> Fatigue <input type="checkbox"/> Trauma <input type="checkbox"/> Other	<b>Hematologic</b> Negative____ <input type="checkbox"/> Anemia <input type="checkbox"/> Leukemia <input type="checkbox"/> Other	<b>Neurological</b> Negative____ <input type="checkbox"/> Epilepsy <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Other	

## Eye History

Date of Last Eye Exam \_\_\_\_\_

Have you ever been diagnosed or treated for the following?

Where? \_\_\_\_\_

Amblyopia/Lazy Eye

Eye Injury

Do you wear contact lenses? YES NO

Cataracts

Glaucoma

Brand \_\_\_\_\_

Corneal Abrasion

Iritis/Uveitis

Solution \_\_\_\_\_

Dry Eye

Macular Degeneration

Eye Infection

Retinal Detachment

Do You....(check if answer is yes)

Work at a computer

Want information about Laser Vision Correction

Think you would benefit from thinner/lighter lenses

Have interest in a non-surgical approach to vision correction

Spend time outdoors

Have more than one pair of glasses with current prescription

Have prescription sunglasses

Wear bifocals and get bothered by the lines or head-tilting

Prefer not to wear glasses at times

Wear contacts and are unsatisfied by vision and/or comfort

Have interest in our Contact Lens Success Program

Have family members in need of eye care

## Family Medical/Eye History

Is there a family history of any of the following? (if yes, please state relationship)

Diabetes

Glaucoma

High Blood Pressure

Lazy Eye

Blindness

Macular Degeneration

Cataracts

Retinal Detachment