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

______________________________ SS# ______________________________

Home Phone __________________ Work Phone __________________ Cell Phone __________________

E-mail Address ______________________________________

Why do we ask for your e-mail address? Providing an email address allows us to grant you complementary access to our online patient portal containing information such as exam data, account information, and appointment history. The portal also allows you to track the status of glasses and/or contact lens orders.

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? ______________________________

Family Medical/Eye History

Is there a family history of any of the following? (if yes, who?)

- ☐ Diabetes ________________________
- ☐ Glaucoma ________________________
- ☐ High Blood Pressure ________________________
- ☐ Lazy Eye ________________________
- ☐ Blindness ________________________
- ☐ Macular Degeneration ________________________
- ☐ Cataracts ________________________
- ☐ Retinal Detachment ________________________

Patient Medical History

Primary Care Physician ______________________ Date of Last Physical Exam ______________

Current Medications

Medication Allergies Yes No

______________________ ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

Review of Systems

Allergic/Immunologic Negative____
- ☐ Environmental
- ☐ Rheumatoid Arthritis
- ☐ Lupus
- ☐ Other

Cardiovascular Negative____
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Stroke
- ☐ Vascular Disease
- ☐ Other

Constitutional Negative____
- ☐ Weight Loss
- ☐ Fever
- ☐ Fatigue
- ☐ Trauma
- ☐ Other

Endocrine Negative____
- ☐ Type I Diabetes
- ☐ Type II Diabetes
- ☐ Thyroid Dysfunction
- ☐ Other

GI Negative____
- ☐ Crohn's Disease
- ☐ Colitis
- ☐ Ulcer
- ☐ Other

Hematologic Negative____
- ☐ Anemia
- ☐ Leukemia
- ☐ Other

Integumentary Negative____
- ☐ Eczema
- ☐ Psoriasis
- ☐ Rosacea
- ☐ Other

Musculoskeletal Negative____
- ☐ Ankylosing Spondylitis
- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Other

Neurological Negative____
- ☐ Epilepsy
- ☐ Multiple Sclerosis
- ☐ Other

Psychiatric Negative____
- ☐ Depression
- ☐ Panic Disorder
- ☐ Schizophrenia
- ☐ Other

Respiratory Negative____
- ☐ Cigarette Smoker
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Other

Eye History

Date of Last Eye Exam ______________

Where? ______________

Do you wear contact lenses? YES NO

Brand ______________

Solution ______________

Have you ever been diagnosed or treated for the following?

- ☐ Amblyopia/Lazy Eye
- ☐ Cataracts
- ☐ Corneal Abrasion
- ☐ Dry Eye
- ☐ Eye Infection
- ☐ Eye Injury
- ☐ Glaucoma
- ☐ Iritis/Uveitis
- ☐ Macular Degeneration
- ☐ Retinal Detachment

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

- ☐ Work at a computer
- ☐ Think you would benefit from thinner/lighter lenses
- ☐ Spend time outdoors
- ☐ Have prescription sunglasses
- ☐ Prefer not to wear glasses at times
- ☐ Have interest in our Contact Lens Success Program
- ☐ Want information about Laser Vision Correction
- ☐ Have interest in a non-surgical approach to vision correction
- ☐ Have more than one pair of glasses with current prescription
- ☐ Wear bifocals and get bothered by the lines or head-tilting
- ☐ Wear contacts and are unsatisfied by vision and/or comfort
- ☐ Have family members in need of eye care

We are accepting new patients! Please introduce us to your family and friends by liking us on Facebook.