

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____ <input type="checkbox"/> Environmental <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Lupus <input type="checkbox"/> Other	Endocrine Negative____ <input type="checkbox"/> Type I Diabetes <input type="checkbox"/> Type II Diabetes <input type="checkbox"/> Thyroid Dysfunction <input type="checkbox"/> Other	Integumentary Negative____ <input type="checkbox"/> Eczema <input type="checkbox"/> Psoriasis <input type="checkbox"/> Rosacea <input type="checkbox"/> Other	Psychiatric Negative____ <input type="checkbox"/> Depression <input type="checkbox"/> Panic Disorder <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Other
Cardiovascular 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	GI Negative____ <input type="checkbox"/> Crohn's Disease <input type="checkbox"/> Colitis <input type="checkbox"/> Ulcer <input type="checkbox"/> Other	Musculoskeletal Negative____ <input type="checkbox"/> Ankylosing Spondylitis <input type="checkbox"/> Arthritis <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Other	Respiratory Negative____ <input type="checkbox"/> Cigarette Smoker <input type="checkbox"/> Asthma <input type="checkbox"/> Bronchitis <input type="checkbox"/> Emphysema <input type="checkbox"/> Other
Constitutional Negative____ <input type="checkbox"/> Weight Loss <input type="checkbox"/> Fever <input type="checkbox"/> Fatigue <input type="checkbox"/> Trauma <input type="checkbox"/> Other	Hematologic Negative____ <input type="checkbox"/> Anemia <input type="checkbox"/> Leukemia <input type="checkbox"/> Other	Neurological 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? _____

Do you wear contact lenses? YES NO

Brand _____

Solution _____

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.