EYE APPEAL
MASTERS IN VISION

Patient Information Form

PATIENT INFORMATION

Full Name _____ Birthdate _____

Street Address _____ City _____ State _____ Zip _____

Mailing Address (if different) _____

Home Phone _____ Social Security # _____

Cell Phone _____ Email Address _____

Check Appropriate Boxes ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Male ☐ Female

Employer _____ Occupation _____ Work Phone _____

Spouse's Name _____ Employer _____ Work Phone _____

If you are a new patient, how did you hear about Eye Appeal ? ☐ Friend ☐ Yellow Pages ☐ Web Site

☐ Advertisement ☐ MD Other _____

INSURANCE INFORMATION

Primary Insurance _____ Contract # _____

Subscriber's Name _____ Subscriber's Birthdate _____

Secondary Insurance _____ Contract # _____

Subscriber's Name _____ Subscriber's Birthdate _____

Primary Care Physician _____ Referring Physician (if different) _____

For patients under 19, or if you are covered under parent's insurance:

Father's Name _____ Social Security # _____

Employer _____ Work Phone _____

Mother's Name _____ Social Security # _____

Employer _____ Work Phone _____

Please note that all fees and copayments are due at the time of your visit and can be paid by cash, check or credit card. If you pay by check and it is returned for any reason, you will be charged a $15.00 service charge.

RELEASE OF INFORMATION

I assign all medical/surgical benefits to Eye Appeal Masters in Vision for services performed by Eye Appeal Masters in Vision staff and authorize the release of information concerning my care to the health insurance agency listed above.

I understand and agree that, regardless of insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. Furthermore, I understand that if my account is turned over for collection that I will be responsible for all fees and expenses incurred by any collection agency or attorney.

SIGNED _____ **Date** _____

Patient/ Guardian/ Responsible Individual - must be 18 or older to sign

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Patient Healthcare Questionaire

Name _____ DOB _____ Date _____

List all medications you currently take (prescription and over-the-counter)

_____

_____

Do you have allergies to any medications? Y / N If yes, please list _____

List all major illnesses or injuries _____

_____

List any surgeries you have had _____

_____

Date of last eye exam _____ Do you drive? Y / N

Do you wear contact lenses? Y / N Do you wear glasses? Y / N

Occupation _____ Hobbies _____

Do you smoke? No / Yes-how much? _____ / day How long? _____ years

Are you having any problems with your eyes? Y / N If yes, please explain _____

_____

_____

GENERAL (if yes, explain in space provided) Explanation

Ears, Nose, Throat (sinus, cough, dry mouth, etc.)	Y / N	_____
Cardiovascular (heart, blood pressure, stroke, etc.)	Y / N	_____
Respiratory (asthma, emphysema, etc.)	Y / N	_____
Gastrointestinal (stomach ulcers, intestinal, etc.)	Y / N	_____
Genital, Kidney, Bladder	Y / N	_____
Muscles, Bones, Joints (arthritis, etc.)	Y / N	_____
Skin (acne, warts, skin cancer, etc.)	Y / N	_____
Neurological (multiple sclerosis, headaches, seizures, etc.)	Y / N	_____
Endocrine (diabetes, thyroid, etc.)	Y / N	_____
Blood, Lymph (high cholesterol, anemia, etc.)	Y / N	_____
Allergic, Immunologic (hay fever, lupus, etc.)	Y / N	_____
General Health (fever, weight gain or loss, unusually tired)	Y / N	_____
Psychiatric (depression, anxiety, etc)	Y / N	_____

FAMILY HISTORY (Parents, siblings, grandparents)

Blindness	Y / N	Glaucoma	Y / N	Hypertension	Y / N
Macular Degeneration	Y / N	Diabetes	Y / N	Heart Disease	Y / N

Other Serious Diseases? _____

Eye Doctor's Signature _____ Date _____

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Patient Lifestyle Form

In helping us we ensure that the eyewear you receive will enable you to successfully perform all of your daily activities; whether it is for work or play, we request that you fill out this brief questionnaire. This information will allow us to better assist you in making the eyewear choices most beneficial to your lifestyle.

Name: _____ Date Completed: _____

Occupation: _____ Age: _____ Sex: ☐ Male ☐ Female

1. What recreational hobbies or activities do you enjoy? Check all that apply.
   - ☐ Golf ☐ Running ☐ Racquetball ☐ Football
   - ☐ Tennis ☐ Snow Skiing ☐ Baseball/Softball ☐ Boating
   - ☐ Water Sports ☐ Fishing ☐ Basketball ☐ Other _____

2. What interests and hobbies do you enjoy? Check all that apply.
   - ☐ Reading ☐ Gardening ☐ Knitting ☐ Crafts
   - ☐ Watching TV ☐ Cooking ☐ Video Games ☐ Painting
   - ☐ Internet ☐ Sewing ☐ Woodworking ☐ Other _____

3. What job requirements do you have? Check all that apply.
   - ☐ Computer Work ☐ I Work Outdoors
   - ☐ Considerable Reading ☐ My Job Necessitates Safety Eyewear
   - ☐ I Work Under Fluorescent Lighting ☐ Other _____

4. Are you experiencing any difficulties with your glasses and/or contact lenses with these activities? Check all that apply.
   - ☐ Glare ☐ Inconsistent Vision
   - ☐ Fogging ☐ Other: _____
   - ☐ Constant Adjustment _____

5. Are your lenses scratched or damaged from regular use? ☐ Yes ☐ No
6. Do you spend more than two hours a day viewing a computer screen? ☐ Yes ☐ No
7. Do you consider yourself sensitive to sunlight? ☐ Yes ☐ No
8. Do you spend more than one hour a day in the sun? ☐ Yes ☐ No
9. Do you have difficulties driving at night? ☐ Yes ☐ No
10. Are your current glasses uncomfortable or cause indentations on your nose? ☐ Yes ☐ No
11. Would thinner lighter lenses appeal to you? ☐ Yes ☐ No
12. Would you like a frame style change? ☐ Yes ☐ No
13. List “designer” labels you include in your wardrobe.

    _____ _____

    _____ _____

14. Which statement(s) best describe yourself?
    - ☐ I lead an active lifestyle (exercise and recreation).
    - ☐ I enjoy being outdoors as much as possible.
    - ☐ I try to keep up with the latest fashion trends.
    - ☐ I am allergic to nickel products.