**Vision Source!®**
**WELCOME TO OUR OFFICE**

# *Clearview Eyecare*
**OPTOMETRY**

**Today's Date** _____

## Patient Information

Last _____
First _____ MI _____
Address _____
City _____ State _____
Zip Code _____
Day Phone _____ Cell Phone _____
Patient's SSN _____
Employer (or School) _____
Occupation (or Grade) _____
Date of Birth _____ Age _____
If Minor, Party Responsible _____
Work Phone _____
Driver's License _____
Spouse (or Parent's) Work _____
Patient Sex M F
Email Address _____
Would you like to receive email newsletters? Y N
What is the major purpose of this visit?

_____

Any problems with your current contact lenses or glasses?

_____

_____

***VERY IMPORTANT! NEW PATIENTS ONLY:***
Who may we thank for referring you to our office?
Name of friend, relative or Dr._____

If not referred, how did you choose our office?
❑ Insurance List
❑ Saw Sign/Building
❑ Newspaper/Radio/TV
❑ Yellow Pages: Which directory? _____
❑ Web Page: Which Web Site? _____
❑ Other _____

***The mission of Clearview Eyecare is to contribute to a lifetime of healthy vision, providing each patient with the highest quality vision and eye health care. We will seek continuing education to remain at the forefront of our profession and will offer the latest eye care technology, professional services, and products. The visual needs and wellness of each patient will always be our first priority.***

## Insurance Information

***Please note that most vision plans DO NOT cover the Contact Lens Evaluation and Follow Up Care.***

**Vision Insurance**_____
Subscriber Name_____
Subscriber ID# _____
Subscriber Birth Date_____

**Medical Insurance**_____
Subscriber Name_____
Subscriber ID# _____
Subscriber Birth Date_____

If you participate in a flex spending account, please request a receipt.

**Payment is due upon completion of service. For your convenience we accept: Cash, Check and Credit Card.**

## Lifestyle Questions

**Do you……(check box if your answer is yes)**

❑..work at a computer? Hours per day_____
❑..think you might benefit from thinner, lighter lenses?
❑..spend time outdoors? How much? _____
❑..have prescription sunwear?
❑..prefer not to wear your glasses at times?
❑..have interest in a non-surgical approach to vision correction?
❑..have more than 1 pair of current Rx eyewear?
❑..have family members in need of eyecare?

## Patient Eye History

**Have you ever experienced, been diagnosed or treated for any of the following eye conditions?**

❑ Blurry Vision
❑ Cataracts
❑ Crossed eye/Eye turn
❑ Eye Infections
❑ Flash of light
❑ Glaucoma
❑ Headaches
❑ Itchiness
❑ Macular Degeneration
❑ Retinal Detachment
❑ Tearing
❑ Uncomfortable glasses
❑ Other eye disorders_____
❑ Burning
❑ Corneal Abrasions
❑ Double Vision
❑ Eye Injury
❑ Floaters/Spots
❑ Grittiness
❑ Iritis/Uveitis
❑ Lazy Eye
❑ Occasional dryness
❑ Sunlight Sensitivity
❑ Trouble seeing at night

**The information in this confidential case history form is critical to the evaluation of your vision and health.**

## Patient Medical History

Name of Family Physician_____
Town_____
Date of Last Physical Check-up_____

**CURRENT MEDICATIONS (Rx or Over the Counter)**
(List name of medications including eye drops, vitamins, & birth control pills)_____

_____

_____

Allergies to medications? ❑ Yes ❑ No
If so, what medications?_____
_____

Have you had any surgeries? ❑ Yes ❑ No
Do you use cigarettes/tobacco, alcohol, or other substances? ❑ Yes ❑ No

**Have you ever been diagnosed or treated for the following health problems?**

❑ Allergies
❑ Arthritis
❑ Blood/Lymph
❑ Bronchitis
❑ Cancer
❑ Cholesterol
❑ Diabetes
❑ Digestive
❑ Ears/Nose/Throat
❑ Endocrine
❑ Eczema/Rashes
❑ Fatigue
❑ Fevers
❑ Genitourinary
❑ High Blood Pressure
❑ Headaches
❑ Kidney
❑ Muscle/Bone
❑ Neurological
❑ Psychological
❑ Respiratory
❑ Sinus
❑ Throat Infections
❑ Thyroid
❑ Unusual weight losses/gains

## Patient Eye History

Date of Last Eye Exam_____
Where? _____

Do you currently wear glasses? ❑ Yes ❑ No

Are you satisfied with the vision and comfort of your current glasses? ❑ Yes ❑ No

If you wear bifocals, do the lines or head tilting bother you? ❑ Yes ❑ No

Do you currently wear contact lenses? ❑ Yes ❑ No
What kind?_____
Solutions used_____

Are you satisfied with the vision and comfort of your current contact lenses? ❑ Yes ❑ No

## Family Medical/Eye History (Check all that apply)

**Is there a family medical history of any of the following:**

| | Relationship (Mother's or Father's side) |
|---|---|
| Blindness | ❑_____ |
| Cataracts | ❑_____ |
| Corneal Problems | ❑_____ |
| Diabetes | ❑_____ |
| Glaucoma | ❑_____ |
| Heart Disease | ❑_____ |
| Lazy Eye | ❑_____ |
| Macular Degeneration | ❑_____ |
| Retinal Problems | ❑_____ |

## Insurance Authorization - Signature On File

Please be advised if you are using insurance coverage for today's visit, this is a contract between you and your insurance company, not Clearview Eyecare. I authorize Clearview Eyecare to act as my agent in helping me obtain payment from my insurance carriers. I authorize payment directly to Clearview Eyecare. I permit a copy of this authorization to be used in place of the original.

If your insurance company has not reimbursed our office in full within 90 days, you will be billed.

Signature_____

***Clearview Eyecare***
**OPTOMETRY**