



Welcome to our office

Title () Last name First name MI Date
(Mr., Mrs., Ms., Miss, Dr.)

Name you wish to be called E-Mail

Home Address City State Zip

Age Birthdate SSN Referred By

Employer/School Occupation (Please mark preferred)

Name of Parent, Legal Guardian or Spouse

Name of family members whom we have provided care

Insurance Company ID# Subscriber

Subscriber name Relationship to patient Birthdate

Medical History:/ Review of Systems:

List any medications you are now taking (including eye drops, birth control pills, vitamins or over the counter medications):

Are you allergic to any medications? Yes No Please list:

Primary Care Physician: Pediatrician:

Preferred Pharmacy:

Do you have or have ever had any of the following problems:

- Yes No Chronic fever, unexpected weight loss/gain, fatigue
Yes No Ear/nose/throat (hearing loss, sinus)
Yes No Seasonal Allergies
Yes No Endocrine Problems
Yes No Diabetes
Yes No Thyroid Problems
Yes No Gastrointestinal Problems (ulcer, abdominal pain, diarrhea)
Yes No Heart Problems
Yes No High Blood Pressure
Yes No Musculoskeletal Problems
Yes No Arthritis
Yes No Neurologic (numbness, weakness, headaches, prior stroke)
Yes No Migraine/Headache
Yes No Psychiatric Problems (depression, anxiety)
Yes No Respiratory Problems (shortness of breath, weezing)
Yes No Asthma/COPD
Yes No Skin Problems (rashes, excessive dryness, rosacea)
Yes No Urinary Problems (pain or discomfort, blood in urine)

Pregnant/Nursing Other Condition/Illness

List any previous major injuries/surgeries/hospitalizations:

Eye History: Do you have or have ever had any of the following problems:

- Dry Eye Cataracts Double Vision Lazy/Crossed Eye Eye Injury Eye Surgery Flashes/Floaters
Glaucoma Retinal Detachment Loss of Vision Macular Degeneration Blurred Vision Other:

Family History (Mother, Father, Grandparents, Sibling):

- Glaucoma Macular Degeneration Retinal Detachment Blindness Cataract Lazy/Crossed Eye
Diabetes High Blood Pressure Other Eye Disease or Condition:

Last eyecare provider Date of last eye exam

Are you currently having eye or vision problems? Yes No

If yes, please explain

Do you wear glasses? Yes No How old are they? Are they bifocals? Yes No Are they for Reading Distance Both

Have you ever worn contact lenses? Yes No If yes, when were they prescribed?

Do you wear contact lenses now? Yes No If not, why did you quit?

Are you interested in wearing contact lenses? Yes No



Social History

Marital Status Single Married Other

Do you drive? Yes No If yes, do you have visual difficulty when driving? Yes No If yes, please describe:

Do you use tobacco products? Yes No _____

Do you drink alcohol? Yes No _____

Do you use illegal drugs? Yes No _____

Have you ever been exposed to or infected with: Hepatitis HIV

If patient is 18 or under, please complete:

Any prenatal, perinatal or postnatal problems? Yes No _____

Any developmental problems? Yes No _____

Do you have any concerns with your child's school performance? _____

Clarkson Eyecare prescribes high quality contact lenses to improve your vision and your lifestyle. Contact lenses are FDA regulated medical devices that can cause discomfort, infections and even permanent vision loss if not cared for properly. New and existing contact lens wearers require additional time and testing during an eye examination to minimize the risk of serious eye problems. This additional testing is only done for contact lens wearers, not for patients who do not wear contact lenses. For this reason, there are additional contact lens evaluation and services fees for new and existing contact lens wearers. Your contact lens evaluation and services fee includes:

1. Specific curvature measurements on the cornea
2. Evaluation of current and new lenses to insure optimal fit, vision and comfort
3. Medical assessment of the cornea, tear film and conjunctiva as they relate to contact lens wear
4. Instructions regarding safe contact lens wear, care and proper solutions
5. Contact lens follow up care for 90 days

If you have any questions, please do not hesitate to speak with your doctor.

Payment for all services and products is the responsibility of the patient.

I agree to pay all copays, deductibles, co-insurances and non covered services as determined by my insurance company.

I understand there is a returned check fee applied to every returned check.

I agree to pay an additional collection fee for all accounts not paid in the time stated on the final monthly statement.

I authorize the release of medical information concerning my illness and treatment by Clarkson Eyecare to my insurance company. I also authorize release of my personal medical information to any doctor whom I may be referred to.

I understand verification of eligibility is not a guarantee of payment as stated by my insurance company.

I authorize payment of my insurance benefits to Clarkson Eyecare.

Signature of patient or legal guardian

Today's Date

Reviewed by Dr. _____

Date: _____

Dr. _____

Date: _____

Dr. _____

Date: _____

We will file all insurance forms if Clarkson Eyecare is a participating provider for your plan.
We will supply you with an itemized statement which you may submit to your insurance carrier.
PAYMENT IN FULL IS REQUIRED AT TIME OF SERVICE.