



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 _____ Cell _____

Name of Parent, Legal Guardian or Spouse _____ Home _____

Name of family members whom we have provided care _____ Work _____

Insurance Company _____ ID# _____ Subscriber _____

Subscriber name _____ Relationship to patient _____ Birthdate _____

Eye History:

- Eye Injury
- Flashes/Floaters
- Double Vision
- Eye Surgery
- Loss of Vision
- Cataracts
- Macular Degeneration
- Glaucoma
- Blurred Vision
- Dry Eye
- Lazy/Crossed Eye
- Migraine/Headache

Medical History:

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 If yes, what medication(s) _____

Do you have any of the following?

Thyroid Disease High Blood Pressure Heart Disease Asthma Diabetes Prior Stroke

Pregnant/Nursing Other Condition/Illness _____

List any previous major injuries/surgeries/hospitalizations: _____

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

Diabetes High Blood Pressure Blindness Cataract Glaucoma Macular Degeneration

Retinal Detachment Lazy/Crossed Eye Other Eye Disease or Condition: _____

Review of Systems:

Do you have any of the following problems? If YES, please explain:

- Heart Problems (chest pain, high blood pressure) Yes No _____
- Respiratory Problems (shortness of breath, asthma, weezing) Yes No _____
- Gastrointestinal Problems (ulcer, abdominal pain, diarrhea) Yes No _____
- Urinary Problems (pain or discomfort, blood in urine) Yes No _____
- Skin Problems (rashes, excessive dryness, rosacea) Yes No _____
- Musculoskeletal Problems (arthritis, etc.) Yes No _____
- Neurologic Problems (numbness, weakness, headaches) Yes No _____
- Psychiatric Problems (depression, anxiety) Yes No _____
- Chronic fever, unexpected weight loss/gain, fatigue Yes No _____
- Ear/nose/throat (hearing loss, sinus, seasonal allergies) Yes No _____
- Endocrine Problems (diabetes, thyroid problems) Yes No _____

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

Primary Care Physician: _____ Pediatrician: _____



Social History

Marital Status Single Married Divorced 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 you 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.