Patient Information & Medical History

First Name: ______________________ Last Name: ____________________________ Middle Initial: _____Sex: **M / F**

Preferred Name: __________________Birth Date: ______________________Social Security Number: ______________________

Home Address: ____ Zip: __________ City: __________________ State: _______

What is your occupation? ____________________________________

Race: ☐ African/African American ☐ Asian/Asian American ☐ Caucasian/European American ☐ Native American ☐ Other ☐ Decline

Ethnicity: ☐ Non-Hispanic ☐ Hispanic / Latino

Height:__________ Weight:_________

How would you prefer we contact you? ☐ **Home** ☐ **Work** ☐ **Cell** ☐ **E-mail** E-mail address ____

Home Phone: _________________ Work Phone: _________________ Cell Phone: __________________________

Marital Status: ☐ **Single** ☐ **Married** How did you hear about us? ______________________ ***We must have a copy of all insurance cards on the day of service***

Primary Medical Insurance: ____ Secondary Medical Insurance: _________________________________

Vision Insurance: _________________ Insured's Name_________________ Insured Social Security Number: _________________________________

Insured's Birth Date:____ Insured's Employer: ____

Family Doctor: ____ Family Dr. Clinic/Phone: _____________________________________

Family Members: ____ For ease of data transfer, are they patients at this office? **Y / N**

NOTICE OF PRIVACY PRACTICES: I/We have been offered a copy of Essential Eyes statement on privacy practices
AUTHORIZATION TO RELEASE INFORMATION: I/We hereby authorize Essential Eyes to release any medical or incidental information that may be necessary for medical benefit of in processing applications for financial benefit. This includes but is not limited to my insurance company, Rehabilitation Services, Social Security Administration, and Worker's Compensation.
CONSENT FOR TREATMENT: I/We hereby authorize Essential Eyes to administer diagnostic and medical procedures as may be necessary for proper health care.
OFFICE POLICY ON PAYMENT: I understand that I am responsible for payment of all charges. As a courtesy, my insurance will be billed for me. It is my responsibility to pay any deductible, copay or any other balance not paid by my insurance company. I authorize insurance benefits to be paid directly to the provider.
VISION PLAN COVERAGE: I/We understand that only one vision plan may be used for exam/materials per visit-per patient and that the vision plan to be used must be chosen before the exam occurs and can not be billed or changed at a later date.

SIGNATURE: ______________________________________ DATE: _____________________________________

CHIEF COMPLAINT

How can we help you today? In this space please check/explain any signs and/or symptoms you are experiencing. Medical insurance will only cover if there is a medical reason for the exam/test such as loss of vision, headaches, eye pain, eye itching or burning, redness, glaucoma, cataracts, floaters, dry eyes, etc.

☐ **Loss of vision**	☐ **Floaters**	☐ **Eye pain/soreness**	☐ **Glare**	☐ **Dry eyes**
☐ **Blurred vision**	☐ **Crossed eyes**	☐ **Watery eyes**	☐ **Light sensitivity**	☐ **Red eyes**
☐ **Double vision**	☐ **Flashes of light**	☐ **Sandy/gritty feeling**	☐ **Tired eyes**	☐ **Burning/itching**

Other (explain):

HISTORY OF PRESENT ILLNESS

Location *Which eye has the problem?* ☐ **Right** ☐ **Left** ☐ **Both**
Quality *How is it effecting you?* ☐ **Bothersome** ☐ **Aware** ☐ **Painful**
Severity *How severe is the problem?* ☐ **Mild** ☐ **Moderate** ☐ **Severe**
Duration *How long have you had the problem?* ______________________

Timing *Is it new, ongoing, returning?* ☐ **New** ☐ **Ongoing** ☐ **Returning**
Context *Associated w/:* ☐ **Infection** ☐ **Medical condition** ☐ **Injury** ☐ **Surgery**
Modifiers *Previous treatment?* ☐ **Drops** ☐ **Medication** ☐ **Other:** _________
Symptoms *Are there associated symptoms?* ☐ **Headache** ☐ **Other:** _________

FAMILY HISTORY

Has anyone in your family been diagnosed with any of the following (check all that apply):

☐ **No problems** ☐ **Diabetes** ☐ **High blood pressure** ☐ **Cancer**
Who: __________ ____________ ____________

Has anyone in your family been diagnosed with any of the following eye problems (check all that apply):

☐ **No problems** ☐ **Glaucoma** ☐ **Amblyopia** ☐ **Cataracts** ☐ **Macular degeneration** ☐ **Strabismus (eye turn)**
Who: __________ ____________ ____________ ___________________ ____________________

SOCIAL HISTORY

Tobacco Use ☐ **Y** ☐ **N** ☐ **Former**
If yes, what type do you use? ☐ **Vape** ☐ **Cigarettes** ☐ **Cigars** ☐ **Pipe** ☐ **Dip/Snuff**
How much per month do you smoke? _______________

Do you consume alcohol? ☐ **Y** ☐ **N**
If yes, how often do you drink? ☐ **Socially** ☐ **Daily**

CURRENT VISION Last Vision Exam____________ Last Eye Doctor______________

Glasses: Do you currently wear glasses? ☐ **Y** ☐ **N** *if yes, answer the questions below; if no, continue to contact lenses section:*
What type of lenses are in your glasses? ☐ **Single vision** ☐ **Bifocal** ☐ **Trifocal** ☐ **No-line (Progressive)**

Contact Lenses: Do you currently wear contact lenses? ☐ **Y** ☐ **N** *if yes, answer the questions below; if no, continue to past ocular history section:*
What type of contact lenses do you wear? ☐ **Soft** ☐ **Rigid**
What is the manufacturer/model of your contact lenses? ________________________________
What are the powers of your contact lenses (if you know)? ________________________________
How old are your current contact lenses? ______ **Months / Years**
Do you sleep in your contact lenses? _______ How many nights in a row? _________________________
How often do you replace your contact lenses? ☐ **Daily** ☐ **Weekly** ☐ **2 weeks** ☐ **Monthly** ☐ **3 months** ☐ **6 months** ☐ **Annually**
What solutions do you use to care for contact lenses? ☐ **Renu** ☐ **Optifree** ☐ **Clear Care** ☐ **Boston Advance** ☐ **Boston Simplicity** ☐ **Optimum** ☐ **Other:** ______

REVIEW OF SYSTEMS

Ocular/Eye Problems
- Inflammatory disorder ☐ **Y** ☐ **N**
- Surgery ☐ **Y** ☐ **N**
- Glaucoma ☐ **Y** ☐ **N**
- Amblyopia (lazy eye) ☐ **Y** ☐ **N**
- Cataract ☐ **Y** ☐ **N**
- Retinal problems ☐ **Y** ☐ **N**
- Macular degeneration ☐ **Y** ☐ **N**
- Strabismus (eye turn) ☐ **Y** ☐ **N**
- Patching ☐ **Y** ☐ **N**
- Other ________

Constitutional Problems
- Cancer Type:__________ ☐ **Y** ☐ **N**
- Fatigue ☐ **Y** ☐ **N**
- Developmental disability ☐ **Y** ☐ **N**
- Other ________

Ears, Nose, Mouth, Throat Problems
- Laryngitis ☐ **Y** ☐ **N**
- Dry mouth ☐ **Y** ☐ **N**
- Hearing loss ☐ **Y** ☐ **N**
- Sinusitis ☐ **Y** ☐ **N**
- Other ________

Neurological Problems
- Cerebral palsy ☐ **Y** ☐ **N**
- Multiple sclerosis ☐ **Y** ☐ **N**
- Tumor ☐ **Y** ☐ **N**
- Epilepsy ☐ **Y** ☐ **N**
- Other ________

Psychiatric Problems
- Depression ☐ **Y** ☐ **N**
- Other ________

Cardiovascular Problems
- Vascular disease ☐ **Y** ☐ **N**
- Stroke ☐ **Y** ☐ **N**
- Congestive heart failure ☐ **Y** ☐ **N**
- Heart disease ☐ **Y** ☐ **N**
- High blood pressure ☐ **Y** ☐ **N**
- High Cholesterol ☐ **Y** ☐ **N**
- Other ________

Respiratory Problems
- Emphysema ☐ **Y** ☐ **N**
- Bronchitis ☐ **Y** ☐ **N**
- COPD ☐ **Y** ☐ **N**
- Asthma ☐ **Y** ☐ **N**
- Other ________

Gastrointestinal Problems
- Colitis ☐ **Y** ☐ **N**
- Chron's disease ☐ **Y** ☐ **N**
- Ulcer ☐ **Y** ☐ **N**
- Other ________

Genitourinary Problems
- Prostate disease/cancer ☐ **Y** ☐ **N**
- STD Type:__________ ☐ **Y** ☐ **N**
- Kidney disease ☐ **Y** ☐ **N**
- Other ________

Musculoskelatal Problems
- Ankylosis spondylitis ☐ **Y** ☐ **N**
- Fibromyalgia ☐ **Y** ☐ **N**
- Muscular dystrophy ☐ **Y** ☐ **N**
- Osteoarthritis ☐ **Y** ☐ **N**
- Other ________

Skin Problems
- Rosacea ☐ **Y** ☐ **N**
- Psoriasis ☐ **Y** ☐ **N**
- Eczema ☐ **Y** ☐ **N**
- Other ________

Endocrine Problems
- Insulin dependent diabetes ☐ **Y** ☐ **N**
- Non-insulin diabetes ☐ **Y** ☐ **N**
- Hormonal dysfunction ☐ **Y** ☐ **N**
- Thyroid dysfunction ☐ **Y** ☐ **N**
- Other ________

Blood/Lymph Problems
- Large volume blood loss ☐ **Y** ☐ **N**
- Anemia ☐ **Y** ☐ **N**
- Rheumatoid arthritis ☐ **Y** ☐ **N**
- Other ________

Allergy/Immunologic Problems
- Environmental allergies ☐ **Y** ☐ **N**
- Drug allergies ☐ **Y** ☐ **N**
- Lupus ☐ **Y** ☐ **N**
- Other ________

Do you sometimes experience dry eyes? ☐ **Y** ☐ **N**
Are your eyes sensitive to sunlight? ☐ **Y** ☐ **N**
Do you work at a computer ? ☐ **Y** ☐ **N**
Problems with reflections and/or glare? ☐ **Y** ☐ **N**
Prefer not to wear your glasses at times? ☐ **Y** ☐ **N**
Interested in newer contact lens technology? ☐ **Y** ☐ **N**
Want information on thinner / lighter lenses? ☐ **Y** ☐ **N**
Want information on LASIK vision surgery? ☐ **Y** ☐ **N**
Want a non-surgical option to LASIK? ☐ **Y** ☐ **N**
Do you have any children? ☐ **Y** ☐ **N**
Do you spend time outdoors? ☐ **Y** ☐ **N**

Please list your sporting activities / hobbies:

____

List any medications you are currently taking:

____

____

____

List any medicine allergies:

____

List any other allergies:

____

Essential Eyes

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Acknowledgement of Privacy and Practices

Essential Eyes Privacy Policy and Practices provides information regarding how we may use and disclose protected health information about you. According to HIPPA regulations, you have the right to a copy of the Privacy Policy and Practices before signing this consent form. The terms of our Privacy Policy may change and you may obtain a revised copy through our office.

You have the right to request how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, the agreement will be honored.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, diagnosis, payment, and health care operations including: communications via email, telephone, text messaging, and mail for appointment scheduling and reminders.

You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent.

I understand that:

- Protected health information may be disclosed or used for the treatment, payment, or health care operations.
- Essential Eyes has a Privacy Policy and Practices and the patient has had the opportunity to review the policy.
- Essential Eyes reserves the right to change the Privacy Policy and Practices.
- The patient has the right to restrict uses of their information, but Essential Eyes does not have to agree to those restrictions.
- The patient may revoke this consent in writing at any time and all future disclosures will cease.
- Essential Eyes may condition treatment upon execution of this consent.

I HERBY AUTHORIZE THE FOLLOWING PERSON(S) TO HAVE ACCESS TO MY FINANCIAL AND MEDICAL RECORDS:

Name:________________________________ Relation:________________ Phone:_____________________________

Name:________________________________ Relation:________________ Phone:_____________________________

____ ______________________

Signature Date

I authorize that my email may be used to send contact and glasses prescriptions at the end of my visits. **________**

Initials

(If initials and email address not provided, prescription cannot be sent until written documentation provided to our office)

Verbal consent is not valid