PROGRESSIVE FAMILY EYECARE & OPTIQUE, PC
WELCOME TO OUR OFFICE

Patient Information

Last _____
First _____ **MI** _____
Street _____
City _____ **State** ____
Zip Code _____
Home Phone _____
Work Phone _____
Patient's SSN _____
Employer _____
Occupation (or Grade) _____
Date of Birth _____ **Age** _____
Sex M F
Email Address _____

What is the reason for today's 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 or relative _____
If not referred, how did you choose our office?
❑ Another Dr. ❑ Insurance List
❑ Saw Sign/Building ❑ Newspaper/Radio/TV
❑ Yellow Pages: Which directory? _____
❑ Web Page: Which Web Site? _____
❑ Other _____

The mission of Progressive Family EyeCare & Optique, PC, is to contribute to a lifetime of healthy vision, providing patients with the highest quality vision care and consequent quality of life. 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

Vision Insurance_____
Subscriber Name_____
Subscriber SSN_____
Subscriber Birth Date_____

Primary Medical Insurance_____
Subscriber Name_____
Subscriber SSN_____
Subscriber Birth Date_____
Do you need a referral for todays visit? ____
Do you participate in a flex spending account?
❑ Yes ❑ No
How will you settle your account today?
❑ Cash ❑ Check ❑ Credit Card

Lifestyle Questions

Do you……(check box if your answer is yes)
❑..work at a computer? If yes, please complete computer questionnaire.
❑..have prescription sunwear?
❑..prefer not to wear your glasses at times?
❑..want information on Laser Vision Correction surgery?
❑..have more than 1 pair of current Rx eyewear?

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

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

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

_____

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?	**Yes**	**No**
Allergies	❑	❑
Arthritis	❑	❑
Blood/Lymph	❑	❑
Bronchitis	❑	❑
Cancer	❑	❑
Cholesterol	❑	❑
Diabetes	❑	❑
Digestive	❑	❑
Ears/Nose/Throat	❑	❑
Endocrine	❑	❑
Eczema/Rashes	❑	❑
Fatigue	❑	❑
Fevers	❑	❑
Genitourinary	❑	❑
High Blood Pressure	❑	❑
Integumentary (Skin)	❑	❑
Kidney	❑	❑
Muscle/Bone	❑	❑
Neurological	❑	❑
Psychological	❑	❑
Respiratory	❑	❑
Sinus	❑	❑
Throat Infections	❑	❑
Thyroid	❑	❑
Unusual weight losses/gains	❑	❑

Patient Eye History

Date of Last Eye Exam_____

By Whom?_____

Do you currently wear contact lenses?

❑ Yes ❑ No

What kind?_____

Solutions used_____

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

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

Family Medical/Eye History

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

Blindness ❑_____

Cataracts ❑_____

Corneal Problems ❑_____

Diabetes ❑_____

Glaucoma ❑_____

Heart Disease ❑_____

Lazy Eye ❑_____

Macular Degeneration❑

Retinal Problems ❑_____

Please be advised if you are using insurance for today's visit, this is a contract between you and your insurance company. If a medical diagnosis is found at the routine eye exam, we will bill medical insurance on your behalf. You will be responsible for any medical and vision co-pays.

If your insurance company has not reimbursed our office in full within 30-60 days, we will bill you directly for any uncovered procedures/services.

All frame and lenses are customized and are not returnable. Unopened contact lens boxes are not returnable after 30 days. If I am receiving a contact lens exam I have read, reviewed and understand the contact lens program.

_____ _____

Patient signature **Date**