

PATIENT INFORMATION

Date: _____
Name: _____
Street: _____
City: _____
State: _____ Zip Code: _____
Home Phone: (_____) _____
Daytime Phone: (_____) _____
Cell Phone: (_____) _____
Email: _____

How would you like our office to communicate with you?

Email Text Phone

Date of Birth: _____ Age: _____

Patient's SSN: _____

Sex: M F

Employer (or School): _____

Occupation (or Grade): _____

Spouse (or Parent's Name): _____

If over the age of 18 years, may we discuss your account with the person named above?

Yes No

PCP Name: _____

Pharmacy: _____

Preferred Language: _____

Race:

- American Indian or Alaska Native
 Native Hawaiian or other Pacific Islander
 Asian Black or African American
 White Other

Ethnicity:

Hispanic or Latino Non-Hispanic or Latino

How did you hear about us?

- Friend or Relative: Who? _____
 Magazine Ad: Which? _____
 Another Doctor Insurance List
 Sign/Building Website
 Social Media Other: _____

INSURANCE • PREFERRED PAYMENT

Vision Plan: _____

Subscriber Name: _____

Subscriber SSN: _____

Subscriber Birth Date: _____

Primary Medical Insurance: _____

Subscriber Name: _____

Subscriber SSN: _____

Subscriber Birth Date: _____

How would you like to provide payment today?

- Cash Check or Debit Card Credit Card
 Flexible Spending Account Care Credit

PATIENT EYE HISTORY

Date of last eye exam: _____

Do you currently wear contact lenses? Yes No

If so, what kind? _____

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

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

Would you like to know if you are a good candidate for LASIK (Laser Vision Correction)? Yes No

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

- | | |
|--|---|
| <input type="radio"/> Cataracts | <input type="radio"/> Dry Eyes |
| <input type="radio"/> Crossed Eye/Eye Turn | <input type="radio"/> Iritis/Uveitis |
| <input type="radio"/> Double Vision | <input type="radio"/> Lazy Eye |
| <input type="radio"/> Eye Injury | <input type="radio"/> Macular Degeneration |
| <input type="radio"/> Floaters/Spots in Vision | <input type="radio"/> Retinal Detachment |
| <input type="radio"/> Glaucoma | <input type="radio"/> Other Eye Disorders:
_____ |

OUR MISSION

James Eyecare & Optics Gallery is dedicated to providing the highest quality in patient care and unsurpassed customer service. We're proud to offer one of the largest selections of quality, fashion forward frames and sunglasses coupled with the latest in lens technology and superior lenses. Our staff truly cares about the health of your eyes and your experience in our office.

PATIENT MEDICAL HISTORY	
Current Medications (Rx or OTC):	

Allergies to medications?	<input type="radio"/> Yes <input type="radio"/> No
If so, what medications? _____	

Have you had any surgeries? <input type="radio"/> Yes <input type="radio"/> No	
Please List: _____	

Please Circle:	
Tobacco? No / Smokeless / _____ packs per day/week	
<input type="radio"/> Never Smoker	<input type="radio"/> Former Smoker
<input type="radio"/> Occasional Smoker	<input type="radio"/> Current Smoker
Alcohol? None / Rarely / Monthly / Weekly / Daily	

FAMILY HISTORY		
Do any of the following run in your family?		
	Yes	No
		Relationship to Patient:
Blindness	<input type="radio"/>	<input type="radio"/>
Cataracts	<input type="radio"/>	<input type="radio"/>
Corneal Problems	<input type="radio"/>	<input type="radio"/>
Glaucoma	<input type="radio"/>	<input type="radio"/>
Lazy Eye	<input type="radio"/>	<input type="radio"/>
Macular Degeneration	<input type="radio"/>	<input type="radio"/>
Retinal Problems	<input type="radio"/>	<input type="radio"/>
Arthritis	<input type="radio"/>	<input type="radio"/>
Cancer	<input type="radio"/>	<input type="radio"/>
Diabetes	<input type="radio"/>	<input type="radio"/>
Heart Disease	<input type="radio"/>	<input type="radio"/>
High Blood Pressure	<input type="radio"/>	<input type="radio"/>
Kidney Disease	<input type="radio"/>	<input type="radio"/>
Lupus	<input type="radio"/>	<input type="radio"/>
Thyroid Disease	<input type="radio"/>	<input type="radio"/>
Other	<input type="radio"/>	<input type="radio"/>

Do you currently have any problems in the following areas:				
	Yes	No	Explanation of Problem:	Year of Diagnosis:
Allergies	<input type="radio"/>	<input type="radio"/>	_____	_____
Arthritis	<input type="radio"/>	<input type="radio"/>	_____	_____
Blood/Lymphatic	<input type="radio"/>	<input type="radio"/>	_____	_____
Cancer	<input type="radio"/>	<input type="radio"/>	_____	_____
Cardiovascular	<input type="radio"/>	<input type="radio"/>	_____	_____
Cholesterol	<input type="radio"/>	<input type="radio"/>	_____	_____
Diabetes	<input type="radio"/>	<input type="radio"/>	_____	_____
Digestive	<input type="radio"/>	<input type="radio"/>	_____	_____
Ears/Nose/Throat	<input type="radio"/>	<input type="radio"/>	_____	_____
Endocrine	<input type="radio"/>	<input type="radio"/>	_____	_____
Eczema/Rashes	<input type="radio"/>	<input type="radio"/>	_____	_____
Genital-urinary	<input type="radio"/>	<input type="radio"/>	_____	_____
High Blood Pressure	<input type="radio"/>	<input type="radio"/>	_____	_____
Integumentary (Skin)	<input type="radio"/>	<input type="radio"/>	_____	_____
Kidney	<input type="radio"/>	<input type="radio"/>	_____	_____
Muscle/Bone	<input type="radio"/>	<input type="radio"/>	_____	_____
Neurological	<input type="radio"/>	<input type="radio"/>	_____	_____
Psychological	<input type="radio"/>	<input type="radio"/>	_____	_____
Respiratory	<input type="radio"/>	<input type="radio"/>	_____	_____
Sinus	<input type="radio"/>	<input type="radio"/>	_____	_____
Thyroid	<input type="radio"/>	<input type="radio"/>	_____	_____
Unusual Weight Loss/Gain	<input type="radio"/>	<input type="radio"/>	_____	_____