JAMES EYECARE & OPTICS GALLERY | Look Forward

Welcome to our office!

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? _____

On a scale of 1-5 how satisfied are you with the comfort of your contact lenses? (5 being most satisfied) 1 2 3 4 5

On a scale of 1-5 how satisfied are you with the vision of your contact lenses? (5 being most satisfied) 1 2 3 4 5

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?

◯ Cataracts ◯ Dry Eyes
◯ Crossed Eye/Eye Turn ◯ Iritis/Uveitis
◯ Double Vision ◯ Lazy Eye
◯ Eye Injury ◯ Macular Degeneration
◯ Floaters/Spots in Vision ◯ Retinal Detachment
◯ Glaucoma ◯ Other Eye Disorders: _____

OUR MISSION

At James Eyecare & Optics Gallery, we are dedicated to providing the highest quality patient care and unsurpassed customer service. Our doctors and staff are committed to utilizing the latest technology and advancements in eye care in order to improve the quality of life for our patients. It is our desire to exceed expectations in both our services and our products.

The information in this confidential case history form is critical to the evaluation of your vision and health.

PATIENT MEDICAL HISTORY

Current Medications (Prescription or OTC):

_____

_____

Allergies to medications? ◯ Yes ◯ No

If so, what medications? _____

_____

_____

Have you had any surgeries? ◯ Yes ◯ No

Please List: _____

_____

_____

Please Circle:

Tobacco? No / Smokeless / _____ packs per day/week

◯ Never Smoker ◯ Former Smoker

◯ Occasional Smoker ◯ 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	◯	◯	_____
Cataracts	◯	◯	_____
Corneal Problems	◯	◯	_____
Glaucoma	◯	◯	_____
Lazy Eye	◯	◯	_____
Macular Degeneration	◯	◯	_____
Retinal Problems	◯	◯	_____
Arthritis	◯	◯	_____
Cancer	◯	◯	_____
Diabetes	◯	◯	_____
Heart Disease	◯	◯	_____
High Blood Pressure	◯	◯	_____
Kidney Disease	◯	◯	_____
Lupus	◯	◯	_____
Thyroid Disease	◯	◯	_____
Other	◯	◯	_____

Do you currently have any problems in the following areas:

	Yes	No	Explanation of Problem:	Year of Diagnosis:
Allergies	◯	◯	_____	_____
Arthritis	◯	◯	_____	_____
Blood/Lymphatic	◯	◯	_____	_____
Cancer	◯	◯	_____	_____
Cardiovascular	◯	◯	_____	_____
Cholesterol	◯	◯	_____	_____
Diabetes	◯	◯	_____	_____
Digestive	◯	◯	_____	_____
Ears/Nose/Throat	◯	◯	_____	_____
Endocrine	◯	◯	_____	_____
Eczema/Rashes	◯	◯	_____	_____
Genital-urinary	◯	◯	_____	_____
High Blood Pressure	◯	◯	_____	_____
Integumentary (Skin)	◯	◯	_____	_____
Kidney	◯	◯	_____	_____
Muscle/Bone	◯	◯	_____	_____
Neurological	◯	◯	_____	_____
Psychological	◯	◯	_____	_____
Respiratory	◯	◯	_____	_____
Sinus	◯	◯	_____	_____
Thyroid	◯	◯	_____	_____
Unusual Weight Loss/Gain	◯	◯	_____	_____