

# WELCOME TO BAY FAMILY EYE CARE

## Patient Information

Today's Date \_\_\_\_\_

Last \_\_\_\_\_

First \_\_\_\_\_ MI \_\_\_\_\_

Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

Patient's SSN \_\_\_\_\_

Employer (or School) \_\_\_\_\_

Occupation (or Grade) \_\_\_\_\_

Spouse (or Parent's Name) \_\_\_\_\_

Spouse (or Parent's Work) \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Sex M F

Email Address \_\_\_\_\_

What is the major purpose of this visit?

\_\_\_\_\_

\_\_\_\_\_

Any problems with your current contacts or glasses?

\_\_\_\_\_

\_\_\_\_\_

How did you hear about our practice? \_\_\_\_\_

***The mission of Bay Family Eyecare is to contribute to a lifetime of healthy vision, providing each patient 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. Everything we do shall communicate this.***

## Insurance Information

Vision Insurance \_\_\_\_\_

Subscriber Name \_\_\_\_\_

Subscriber SSN \_\_\_\_\_

Subscriber Birth Date \_\_\_\_\_

Primary Medical Insurance \_\_\_\_\_

Subscriber Name \_\_\_\_\_

Subscriber SSN \_\_\_\_\_

Subscriber Birth Date \_\_\_\_\_

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)**

..plan on getting new glasses today?

..work at a computer? If yes, please complete computer questionnaire.

..think you might benefit from thinner, lighter lenses?

..have interest in a "test drive" of the latest contact lens designs

..spend time outdoors? How much? \_\_\_Hrs/week

..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 children?

..have family members in need of eyecare?

**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 at 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	_____	
Town	_____	
Date of Last Physical Check-up	_____	
<b>CURRENT MEDICATIONS (Rx or Over the Counter)</b> (List name of medications including eye drops, vitamins, & birth control pills)		
_____		
_____		
Allergies to medications?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If so, what medications?	_____	
_____		
Have you had any surgeries?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you use cigarettes/tobacco, alcohol, or other substances?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Have you ever been diagnosed or treated for the following health problems?</b>		
	<b>Yes</b>	<b>No</b>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Blood/Lymph	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Digestive	<input type="checkbox"/>	<input type="checkbox"/>
Ears/Nose/Throat	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine	<input type="checkbox"/>	<input type="checkbox"/>
Eczema/Rashes	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Fevers	<input type="checkbox"/>	<input type="checkbox"/>
Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Integumentary (Skin)	<input type="checkbox"/>	<input type="checkbox"/>
Kidney	<input type="checkbox"/>	<input type="checkbox"/>
Muscle/Bone	<input type="checkbox"/>	<input type="checkbox"/>
Neurological	<input type="checkbox"/>	<input type="checkbox"/>
Psychological	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>
Sinus	<input type="checkbox"/>	<input type="checkbox"/>
Throat Infections	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Unusual weight losses/gains	<input type="checkbox"/>	<input type="checkbox"/>

Patient Eye History	
Date of Last Eye Exam	_____
By Whom?	_____
Have you ever tried contact lenses?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you currently wear contact lenses?	<input type="checkbox"/> Yes <input type="checkbox"/> No
What kind?	_____
Solutions used	_____
Are you satisfied with the vision and comfort of your contact lenses?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Would you prefer clear contact lenses or colored contact lenses?	<input type="checkbox"/> Clear <input type="checkbox"/> Colored
If you wear bifocals, do the lines or head tilting bother you?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Family Medical/Eye History (Check all that apply)	
Is there a family medical history of any of the following:	
<input type="checkbox"/> No	<input type="checkbox"/> Yes (Please check boxes)
	Relationship (Mother's or Father's side)
Blindness	<input type="checkbox"/> _____
Cataracts	<input type="checkbox"/> _____
Corneal Problems	<input type="checkbox"/> _____
Diabetes	<input type="checkbox"/> _____
Glaucoma	<input type="checkbox"/> _____
Heart Disease	<input type="checkbox"/> _____
Lazy Eye	<input type="checkbox"/> _____
Macular Degeneration	<input type="checkbox"/> _____
Retinal Problems	<input type="checkbox"/> _____
As part of our ongoing commitment to excellence in patient service, we will act as your advocate to ensure you receive your full benefits as quoted by your insurance company. Please be advised if you are using insurance coverage for your visit, this is a contract between you and your insurance company...not Bay Family Eyecare. If your insurance company has not reimbursed our office in full within 90 days, your credit card will be utilized and your insurance company will then pay you directly. (If by mistake your insurance company sends the payment check to us, we will of course sign over and forward the check directly to you.)	
Please enter your credit card number and expiration date.	
CC#:	_____
Expiration Date:	_____
Signature	_____