

Mission Optometry

Today's Date: _____

PATIENT INFORMATION

Last Name _____

First Name _____ MI _____

Street _____

City _____

State _____ Zip Code _____

Cell Phone _____

Home Phone _____

Work Phone _____

Patient's SSN _____

Employer/School _____

Occupations/Grade _____

Spouse/Parent's Name _____

Spouse/Parent's Workplace _____

Date of Birth _____ Age _____

Sex: Male Female

Email Address _____

Whom should we notify in case of an emergency?

(name) (telephone) (relationship)

What is the primary purpose of this visit?

Any problems with your current contact lenses or glasses?

LIFESTYLE QUESTIONS

Do you...(check box if your answer is yes)

- ..work at a computer? How much? _____ Hrs/day
- ..think you might benefit from thinner, lighter lenses?
- ..have interest in trying the latest contact lenses?
- ..spend time outdoors? How much? _____ Hrs/week
- ..have prescription sunwear?
- ..prefer not to wear your glasses?
- ..want information on Laser Vision Correction surgery?
- ..have interest in a non-surgical vision correction?
- ..have more than one pair of current Rx eyewear?
- ..have children?
- ..have family members in need of eyecare?
- have interest in skin care, Botox® or Juvederm™?

VERY IMPORTANT!

Whom 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 Company
- Saw Sign/Building
- Yellow Pages
- Web Page
- Other _____

INSURANCE INFORMATION

Vision Insurance _____

Subscriber Name _____

Subscriber SSN _____

Subscriber Birth Date _____

Primary Medical Insurance _____

Subscriber Name _____

Subscriber SSN _____

Subscriber Birth Date _____

I understand that I am responsible for any charges not covered by my medical or vision insurance:

(Signature)

(Date)

MEDICAL HISTORY

List Current Medications (including eye medications):

Last Eye Exam _____

Medical Dr. Name _____

Medical Dr. Phone _____

Last Medical Exam _____

Any known eye disease? _____

Eye injury or surgery? _____

Any allergies? _____

Is there a Family History of (check all that apply):

Relationship To You

- Blindness _____
- Cataracts _____
- Crossed Eyes _____
- Glaucoma _____
- Macular Degeneration _____
- Retinal Detachment _____
- Arthritis _____
- Cancer _____
- Diabetes _____
- Heart Disease _____
- High Blood Pressure _____
- Kidney Disease _____
- Lupus _____
- Thyroid Disease _____
- Other _____

Do you currently have, or have you ever had any problems in the following area?

	No	Yes
<u>Constitutional</u>		
Fever/Weight Loss/Gain	<input type="checkbox"/>	<input type="checkbox"/>
<u>Cardiovascular/Vascular</u>		
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
<u>Ears, Nose, Mouth, Throat</u>		
Allergies/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>
<u>Respiratory</u>		
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
<u>Gastrointestinal</u>		
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>
<u>Genitourinary</u>		
Genitals/Kidney/Bladder	<input type="checkbox"/>	<input type="checkbox"/>
<u>Musculoskeletal</u>		
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
<u>Integumentary</u>		
Skin	<input type="checkbox"/>	<input type="checkbox"/>
<u>Neurological</u>		
Headaches	<input type="checkbox"/>	<input type="checkbox"/>

	No	Yes
<u>Neurological (continued)</u>		
Migraines	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>
<u>Psychiatric</u>		
<u>Endocrine</u>		
Thyroid/Other Glands	<input type="checkbox"/>	<input type="checkbox"/>
<u>Hematologic/Lymphatic</u>		
Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Problem	<input type="checkbox"/>	<input type="checkbox"/>
<u>Allergic/Immunologic</u>		
<u>Eyes</u>		
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>
Distorted Vision	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>
Burning	<input type="checkbox"/>	<input type="checkbox"/>
Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>
Excess Tearing/Watering	<input type="checkbox"/>	<input type="checkbox"/>
Glare/Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Infection of Eye/Lid	<input type="checkbox"/>	<input type="checkbox"/>
Sties or Chalazion	<input type="checkbox"/>	<input type="checkbox"/>
Flashes/Floaters in Vision	<input type="checkbox"/>	<input type="checkbox"/>

Do you use eye drops?
 No Yes – what type? _____

Do your eyes feel dry, painful, or sore?
 Never Sometimes Often Always

Do your experience episodes or periods of blurred vision?
 Never Sometimes Often Always

How often do your eyes feel tired?
 Never Sometimes Often Always

Do you have problems with your eyes when you are working on a computer, watching TV or reading?
 Never Sometimes Often Always

Payment is expected at time services are provided. We accept cash, check, MasterCard, Visa and Discover. A 50% deposit is required on all materials ordered. Balances are due at the time materials are received.

I authorize payment to Mission Optometry and/or Robert J. Joyce, O.D., APC for all benefits now due or becoming due under my Medicare or group insurance policy for the services that have been rendered.

I authorize the release of my (or my child's) medical records as deemed necessary by the staff of Mission Optometry to a Medical Provider or on the request from a Medical Provider. I hereby acknowledge receipt of a copy of my Patient Health Information Privacy Policy.

patient/parent or guardian signature)

(date)