WELCOME TO SHARONVILLE EVENDALE EYECARE

Please complete BOTH sides of this form.

Today's Date ___________________

Patient Information

Name: First ____________________MI_______ Last ______________________________
Address ____
City________________________ State __________Zip Code ______________________

Telephone number(s) **Rank** in the order you would prefer to be contacted:
___Home Phone ______________________________
___Work Phone______________________________
___Cell phone # ______________________________ Ok to text? ___________________
___Email address ______________________________ Ok to email? _________________

Date of Birth___________________ Age __________ Sex: Male / Female

Patient's SSN _______________________ Married Single Divorced Widow/Widower

Employer (or School) ____
Occupation (or Grade) ____
Spouse's (or Parent's) Name ____
Spouse's (or Parent's) Employer ____

What is the major purpose of this visit? ____

Any problems with your current contact lenses or glasses? __________________________

____

Please be sure to give both your vision insurance and major medical insurance information to the front desk staff.

I certify that I, and/or my dependent(s), have insurance coverage with:

____
Name of Insurance Company(ies)

I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Please sign that you have read and understand the above payment policy and Notice of Privacy Practices.

Signature_______________________________________

Patient Medical History

Name of Family Physician ________________________Date of Last Physical Check-up_______________

CURRENT MEDICATIONS (Rx or Over the Counter) If you have a list we are happy to make a copy for our files

____

____

Allergies to medications? Yes No If so, what medications? ___________________________________

Is there a chance you are pregnant? Yes No

Do you use: Cigarettes/Tobacco Alcohol Other substances:_________________________

Have you ever been diagnosed or treated for the following health problems?

Allergies	No	Yes	Genitourinary	No	Yes
Arthritis	No	Yes	High Blood Pressure	No	Yes
Blood/Lymph	No	Yes	HIV	No	Yes
Bronchitis	No	Yes	Integumentary (Skin)	No	Yes
Cancer	No	Yes	Kidney	No	Yes
Cholesterol	No	Yes	Muscle/Bone	No	Yes
Diabetes	No	Yes	Neurological	No	Yes
Digestive	No	Yes	Psychological	No	Yes
Ears/Nose/Throat	No	Yes	Respiratory	No	Yes
Endocrine	No	Yes	Sinus	No	Yes
Eczema/Rashes	No	Yes	Thyroid	No	Yes
Fatigue	No	Yes	Weight loss/gain	No	Yes
Fevers	No	Yes	Other_________________________________		

Patient Eye History

Date of last eye exam ___________________________ By whom? _________________________________

Have you tried contact lenses? No Yes

Do you currently wear contact lenses? No Yes What kind? _______________Hrs/day________

What contact lens solution do you use? ____

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

Blurry Vision	Burning	Cataracts	Corneal Abrasions	Macular degeneration
Double Vision	Eye Infections	Headaches	Flashes of light	Eye injury
Floaters/Spots	Glaucoma	Grittiness	Retinal detachment	Iritis/Uveitis
Itchiness	Lazy Eye	Tearing	Occasional dryness	Sunlight Sensitivity
Crossed eye	Trouble seeing at night		**Eye surgery**______________________	

Family Medical/Eye History Is there a family medical history of any of the following:

No Yes (Please mark boxes) Relationship and state Mother's or Father's side

Blindness	__________________	Cataracts	__________________
Corneal Problems	__________________	Diabetes	__________________
Glaucoma	__________________	Heart Disease	__________________
Lazy eye	__________________	Macular degeneration	__________________
Retinal detachment	__________________	Hypertension	__________________