EYELUX OPTOMETRY

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Please fill out both pages clearly and completely

PERSONAL DEMOGRAPHICS

Title: _____ First:_____ Middle:___ Last:_____ Suffix:_____ Nickname:_____

Address1: _____ City:_____ State:_____ ZIP:_____

Address2: _____ Date of Appointment: _____

Home Phone: (_____) _____-_____ Mobile: (_____) _____-_____ Work Phone: (_____) _____-_____ Ext: _____

Birthdate: _____ Sex: _____ SSN: _____ Email: _____ Pref. Contact: _____

Marital Status: _____ Employment Status: _____

Any household family member been previously examined by one of our doctors? O Yes O No O Not sure

If yes, who in the family? _____

Employer Name (or School): _____ Position (or Grade) _____

How did you first find out about us? O Family, friend, or co-worker O Doctor referral O Eye care plan directory O Exterior sign
O Print advertisement O Internet (which website? _____) O Other _____

If another person recommended us, whom may we thank? _____

PAYMENT INFORMATION

Person Responsible for Account O Self O Other (please indicate) _____

Are you a member of an eye care plan? O Yes O No If yes, please mark your plan(s) below:
O Vision Service Plan (VSP) O Medical Eye Services (MES) O EyeMed / ECPA O Superior Vision O Other _____

OCULAR HISTORY

Reason(s) for your visit today? O Glasses O Contact Lenses O Laser Vision Correction O Eye health evaluation
O School referral O Concern over DMV eye test O Other (please explain) _____

When was your last comprehensive eye examination? O Never O Less than 1 year O 1 year O 2 years O 3 years O 4 years O 5+ years

Describe your computer use: O Extensive (5+ hrs/day) O Moderate (2-5 hrs/day) O Low (less than 2 hrs/day) O Seldom O Never

Eye surgeries: O None O LASIK O PRK O RK O Cataract O Retinal O Glaucoma O Eyelid O Other _____

Eye conditions: O Cataract O Glaucoma O Macular Degeneration O Keratoconus O Other _____

Which statement applies to you? O I've never worn contacts (skip rest of this section) O I wear contacts daily
O I wear contacts occasionally O I used to wear contacts

If you wear contacts, do you sleep with them regularly? O Yes O No
If yes, how many nights in a row will you wear them without removal? _____

Are your contacts (check all that apply): O Soft O Rigid O Disposable O Hybrid (SynergEyes)
O Monovision O Bifocal / Multifocal O For astigmatism O Other _____

If *soft disposable*, which brand and lens power are you wearing (if known) _____

How old is the pair you are currently wearing? _____ How frequently do you replace a pair? _____

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FAMILY OCULAR HISTORY

Please indicate if any of your blood-relatives have the following:		Who in the Family?
Cataracts	O Y O N O Unsure	
Diabetic Retinopathy	O Y O N O Unsure	
Glaucoma	O Y O N O Unsure	
Macular Degeneration	O Y O N O Unsure	

Other eye disease (please specify) _____

PERSONAL MEDICAL HISTORY

Do you take any prescription or non-prescription medicines regularly? O Yes O No (If yes, please list all below or provide as attachment)

_____ _____

_____ _____

_____ _____

Any Allergies to Medicine? O None known O Penicillin O Sulfa drugs O Codeine O Other _____

Any significant conditions of the following medical systems?	**(Please mark)**	**If yes, please specify**
General constitution (fibromyalgia, obesity, anorexia, bulimia)	O Y O N	
Ear / nose / throat (hearing loss, sleep apnea)	O Y O N	
Neurologic (migraine headaches, traumatic brain injury)	O Y O N	
Psychiatric (depression, memory loss, OCD)	O Y O N	
Cardiovascular (high blood pressure, cholesterol, stroke, heart)	O Y O N	
Respiratory (asthma, tuberculosis)	O Y O N	
Gastrointestinal (inflammatory bowel disease, Crohn's disease)	O Y O N	
Genitourinary (kidney failure, prostate/ovarian cancer, pregnant)	O Y O N	
Muscle / joints (Marfan's syndrome, rheumatoid arthritis)	O Y O N	
Skin (eczema, acne rosacea)	O Y O N	
Endocrine (diabetes mellitus, hypo- or hyper-thyroid)	O Y O N	
Blood (anemia, blood clotting disorders, sickle cell)	O Y O N	
Allergic / Immunologic (hayfever, HIV, lupus)	O Y O N	

AVOCATION

So that we understand your vision needs, any hobbies or sports that you enjoy?

PRIVACY PRACTICES ACKNOWLEDGEMENT AND 3RD PARTY PAYMENT AUTHORIZATION

I acknowledge that I have received the EyeLux Optometry's *Notice of Privacy Practices*, available from our office receptionist. You can also review it on our website, www.EyeLuxOptometry.com. Additionally, I authorize the payment of any eye care benefits or medical insurance to EyeLux Optometry. I understand that I may have co-payments, deductibles, and overage costs, and ultimately I am responsible for all fees incurred.

Signature of patient (or parent/guardian for minors) /S/ _____

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