Lake Wylie Eye
Welcome To Our Office

Thank you for choosing us for your eyecare needs. We are delighted to have you as a patient and appreciate the confidence you placed in us. Please take a moment to complete the following information. Any information we already have on file will appear on this form. Please review all completed areas to ensure that the information we have is current and accurate. If you have any questions, please do not hesitate to ask.

☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms. ☐ Male ☐ Female

First Name _____ MI _____ Last Name _____ Preferred Name _____

Street Address _____ City _____ State _____ Zip _____

Social Security Number _____ Date of Birth _____ Home Phone - Include Area Code _____ Day Phone _____

Email Address _____ Guardian _____ Person Responsible for Account _____

Emergency Contact _____ Emergency Phone _____

How were you referred to our office?

☐ Phone Book ☐ School ☐ Advertisement ☐ Patient
☐ Insurance Listing ☐ Drive by ☐ Other ☐ Doctor

Who were you referred by? _____

PRIMARY INSURANCE INFORMATION

Name and Address of Primary Insurance Company _____ City _____ State _____ Zip _____

M ☐ F ☐ Insured's First Name _____ MI _____ Insured's Last Name _____

Insured's Identification Number _____ Group Number _____ Insured's Date of Birth _____

Patient Relationship to Insured

☐ Self ☐ Spouse ☐ Child ☐ Other

Patient Status

☐ Single ☐ Married ☐ Other
☐ Full Time Student ☐ Part Time Student ☐ Employed

SECONDARY INSURANCE INFORMATION

Name and Address of Secondary Insurance Company _____ City _____ State _____ Zip _____

M ☐ F ☐ Insured's First Name _____ MI _____ Insured's Last Name _____

Patient Relationship to Insured

Insured's Identification Number _____ Group Number _____ Insured's Date of Birth _____ ☐ Self ☐ Spouse ☐ Child ☐ Other

Please Read:

In order to control the cost of billing, we ask that the patient's portion is paid at the time services are rendered unless other arrangements are made in advance. We would rather control billing costs than be forced to raise our fees. All professional services and material are charged to the patient.The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Accounts 90 days old are subject to collection fees. There will be a service charge on all returned checks.

Payment from my insurance is to be paid directly to . I understand that will be billed as my primary insurance. I understand that billing any secondary insurance is my responsibility. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed.

Signature _____ Date _____

Name

PATIENT HISTORY AND INFORMATION

PRIMARY CARE PHYSICIAN

Primary Care Physician and Clinic Name

Address of Primary Care Physician City State Zip Phone

REFERRING PHYSICIAN

Referring Physician and Clinic Name

Address of Referring Physician City State Zip Phone

HEALTH HISTORY

What is the main reason for today's exam ? When was your last exam ?

When was your last health exam ?

Past Illnesses or Injuries:

Past Surgeries:

Current Medications:

Current Eye Drops:

Medicines that cause reactions or sensitivities:

Specific Allergies:

EYE HISTORY

Glaucoma	○ Yes ○ No	Dryness	○ Yes ○ No	Strabismus (Crossed Eyes)	○ Yes ○ No
Cataract	○ Yes ○ No	Excess Tearing/Watering	○ Yes ○ No	Blurred Vision Distance	○ Yes ○ No
Macular Degeneration	○ Yes ○ No	Eye Pain or Soreness	○ Yes ○ No	Blurred Vision Near	○ Yes ○ No
Retinal Detachment	○ Yes ○ No	Foreign Body Sensation	○ Yes ○ No	Distorted Vision (halos)	○ Yes ○ No
Color Blindness	○ Yes ○ No	Infection of Eye or Lid	○ Yes ○ No	Double Vision	○ Yes ○ No
Headaches	○ Yes ○ No	Itching	○ Yes ○ No	Floaters or Spots	○ Yes ○ No
Glare/Light Sensitivity	○ Yes ○ No	Mucous Discharge	○ Yes ○ No	Fluctuating Vision	○ Yes ○ No
Tired Eyes	○ Yes ○ No	Drooping Eyelid	○ Yes ○ No	Loss of Vision	○ Yes ○ No
Amblyopia (Lazy Eye)	○ Yes ○ No	Redness	○ Yes ○ No	Loss of Side Vision	○ Yes ○ No
Burning	○ Yes ○ No	Sandy or Gritty Feeling	○ Yes ○ No		

GENERAL HEALTH CONDITION

Fever	○ Yes ○ No	Respiratory (Asthma)	○ Yes ○ No	Anxiety or Depression	○ Yes ○ No
Weight Loss	○ Yes ○ No	Gastrointestinal	○ Yes ○ No	Thyroid, Diabetes	○ Yes ○ No
Other Symptoms	○ Yes ○ No	Kidney	○ Yes ○ No	Blood/Lymph	○ Yes ○ No
Ears,Nose,Throat	○ Yes ○ No	Muscles,Bones,Joints	○ Yes ○ No	Allergic	○ Yes ○ No
Cardiovascular (high blood pressure etc.)	○ Yes ○ No	Skin	○ Yes ○ No	Are you?	☐ Pregnant ☐ Nursing
		Neurological (Multiple Sclerosis)	○ Yes ○ No		

FAMILY HISTORY

Amblyopia (Lazy Eye)	○ Yes ○ No	Retinal Detachment	○ Yes ○ No	High Blood Pressure	○ Yes ○ No
Blindness	○ Yes ○ No	Strabismus (Eye Turn)	○ Yes ○ No	Kidney Disease	○ Yes ○ No
Cataract(s)	○ Yes ○ No	Arthritis	○ Yes ○ No	Lupus	○ Yes ○ No
Color Blindness	○ Yes ○ No	Cancer	○ Yes ○ No	Stroke	○ Yes ○ No
Glaucoma	○ Yes ○ No	Diabetes	○ Yes ○ No	Thyroid Disease	○ Yes ○ No
Macular Degeneration	○ Yes ○ No	Heart Disease	○ Yes ○ No	Others	○ Yes ○ No

Name

MEDICAL HISTORY QUESTIONAIRE

SOCIAL HISTORY

Current Occupation : _____ Years _____ Employer _____

SPECTACLE LENS HISTORY

Do you use a computer? ○ Yes ○ No How many hours/day? _____ Distance from Computer? _____

Do you drive? ○ Yes ○ No Mileage to work each way? _____

Do you have glare problems? ○ Yes ○ No

Do you have visual difficulty when driving? ○ Yes ○ No

Do you have problems with night vision? ○ Yes ○ No

Do you currently wear glasses ? ○ Yes ○ No Since _____

Type of glasses ☐ FullTime ☐ PartTime ☐ Distance ☐ Close

Glasses Owned ☐ SingleVision ☐ Bifocals ☐ Trifocals ☐ Backup ☐ Safety ☐ Sports ☐ Progressive

Have you had trouble in the past with glasses? ○ Yes ○ No _____

Do you wear sunglasses? ○ Yes ○ No Are your sun glasses your current prescription ? ○ Yes ○ No

SPECIAL EYEWEAR NEEDS

☐ Computer (special prescriptions, special anti-glare tints or coatings) ☐ Safety Glasses (gardening, woodworking, welding)
☐ Occupational (mechanics, plumbers, pilots) ☐ Sports/Hobbies (racquet sports, motorcycle)

CONTACT LENS HISTORY

If not a contact lens wearer, are you interested in trying contact lenses at this time ? ○ Yes ○ No

Have you ever tried to wear contact lenses? ○ Yes ○ No Reason for stopping? _____

Do you currently wear contact lenses? ○ Yes ○ No Since _____

Type and brand of contact lenses _____ Today's wearing time ? _____

How many hours/day ? _____ How many days/week ? _____

Please rate the following on a scale of 1-10, with 1 being POOR to 10 being EXCELLENT

	Right	Left		Right	Left		Right	Left
Lens Comfort	_____	_____	Distance Vision	_____	_____	Near Vision	_____	_____

What Solutions do you use? Cleaner _____ Disinfectant _____ Enzyme _____

SOCIAL HISTORY

Do you use nutritional supplements (vitamins etc.)? ○ Yes ○ No

Do you engage in regular exercise? ○ Yes ○ No

Do you drink alcohol ? If yes, how much/often : ○ No ○ Occasional ○ 1 Per Day ○ 2-3/day ○ 4+/day

Do you smoke ? If yes, how much/often : ○ No ○ Occasional ○ 1/2 pack/day ○ 1 pack/day ○ 1+ pack

Method of Tobacco Intake : ○ Smoking ○ Chewing

Do you use Illegal Drugs : ○ Yes ○ No

Hobbies/ Interests : _____