Lifetime Eye Solutions Optometry

Welcome Back To Our Office

Welcome to Lifetime Eye Solutions Optometry. 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. ☐ Dr. ☐ Male ☐ Female

First Name ______ MI ______ Last Name ______ Preferred Name ______

Street Address ______ City ______ State Zip ______

Social Security Number ______ Date of Birth ______ Age ______ Best Phone - Include Area Code ______ Day Phone ______

Email Address ______ Spouse or Parent(s) Name ______ Person Responsible for Account ______

Emergency Contact ______ Emergency Phone ______ How were you referred to our office? ______

Occupation: ______ Employer ______ If student, what grade? ______

Who referred you to our office? ______

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

HIPAA PRIVACY REGULATIONS:

Federal law, the Health Insurance Portability and Accountability Act of 1996, authorized the Department of Health and Human Services to adopt new rules to protect patient privacy. Notification is therefore given that the office of Lifetime Eyecare will not reveal to any person personal information about you or about a family member (i.e. name, address, Social Security number, as well as other health imformation) without permission. Your information will never be sold, or listed for the prupose of advertisement, solicitation or fund raising. It is however understood that within the realm of doing business and for general patient care purposes, your personal information will be necessary and used in the following context: Patient registration; Procure medical records from former physicians; Converse with colleagues for opinions/care; Insurance: verifications, billing, paper and wire (includes fax transmissions); Insurance company follow-up or interaction with billing services relating to patient care; Pursue collection of unpaid bills; Hospital workers, nurses, aids and medicfal records department; Emergency officials, Paramedic, fire personnel, emergency room physicians, nurses or technicians; Personal Religious designate; pharmacists, drug program personnel/workers; completion of disability forms; computer and electronically stored information, (i.e. related business vendor and service persons)

PAYMENTS POLICY:

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.

X ______ Signature X ______ Date

Name

Lifetime Eye Solutions Optometry

PATIENT HISTORY AND INFORMATION

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PRIMARY CARE PHYSICIAN

HEALTH HISTORY

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

When was your last health exam ? ______________

Past Illnesses: ______________ Past Injuries: ______________

Past Surgeries: ______________

Current Medications: ______________

Current Eye Drops: ______________

Drug Allergies ○ Yes ○ No To what Drug(s) ______________

Symptoms of Drug allergies: ______________

EYE HISTORY of Patient

Condition	Yes	No
Glaucoma	○ Yes	○ No
Cataract	○ Yes	○ No
Macular Degeneratio	○ Yes	○ No
Retinal Detachment	○ Yes	○ No
Color Blindness	○ Yes	○ No
Headaches	○ Yes	○ No
Glare/Light Sensitivity	○ Yes	○ No
Tired Eyes	○ Yes	○ No
Amblyopia (Lazy Eye)	○ Yes	○ No
Burning	○ Yes	○ No
Dryness	○ Yes	○ No
Excess Tearing/Watering	○ Yes	○ No
Eye Pain or Soreness	○ Yes	○ No
Foreign Body Sensation	○ Yes	○ No
Infection of Eye Lid	○ Yes	○ No
Itching	○ Yes	○ No
Mucous Discharge	○ Yes	○ No
Drooping Eyelid	○ Yes	○ No
Redness	○ Yes	○ No
Sandy or Gritty Feeling	○ Yes	○ No
Crossed Eyed	○ Yes	○ No
Blurred Vision Distance	○ Yes	○ No
Blurred Vision Near	○ Yes	○ No
Eye Dieases	○ Yes	○ No
Eye Surgeries	○ Yes	○ No
Floater and Spots	○ Yes	○ No
Fluctuating Vision	○ Yes	○ No
Loss of Vision	○ Yes	○ No
Loss of side vision	○ Yes	○ No

GENERAL HEALTH CONDITION of Patient:

Condition	Yes	No
Respiratory (Asthma)	○ Yes	○ No
Gastrointestinal	○ Yes	○ No
Ears,Nose,Throat	○ Yes	○ No
Cardiovascular (high blood pressure etc.)	○ Yes	○ No
Kidney	○ Yes	○ No
Muscles,Bones,Joints	○ Yes	○ No
Skin	○ Yes	○ No
Diabetes	○ Yes	○ No
Neurological (Sclerosis)	○ Yes	○ No
Anxiety or Depression	○ Yes	○ No
Endocrine (Thyroid, Diabetes)	○ Yes	○ No
Blood/Lymph	○ Yes	○ No
Other	○ Yes	○ No

FAMILY HISTORY

Condition	Yes	No
Amblyopia (Lazy Eye)	○ Yes	○ No
Blindness	○ Yes	○ No
Cataracts	○ Yes	○ No
Color Blindness	○ Yes	○ No
Glaucoma	○ Yes	○ No
Macular Degeneration	○ Yes	○ No
Reitnal Detachment	○ Yes	○ No
Stabismus (Eye Turn)	○ Yes	○ No
Arthrits	○ Yes	○ No
Cancer	○ Yes	○ No
Diabetes	○ Yes	○ No
Heart Diease	○ Yes	○ No
High blood Pressure	○ Yes	○ No
Kidney Disease	○ Yes	○ No
Lupus	○ Yes	○ No
Stroke	○ Yes	○ No
Thyroid Disease	○ Yes	○ No

MEDICAL HISTORY QUESTIONAIRE

SOCIAL HISTORY

SOCIAL HISTORY

Current Occupation : ______________________ Years ________

SPECTACLE LENS HISTORY

Do you use a computer? ○ Yes ○ No How many hours/day? ______

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 ☐ FullTime ☐ PartTime ☐ Distance ☐ Close

Type of Glasses Owned

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

CONTACT LENS HISTORY

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

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

Social History

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

Do you use illegal drugs ○ Yes ○ No