

Keen Eye Vision

Welcome To Our Office

Welcome to Keen Eye Vision. 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?

Who were you referred by?

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

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:

A copy of Keen Eye Vision Notice of Privacy Practices has been made available to me.

I acknowledge financial responsibility for all professional services/materials provided by this office regardless of my insurance. Keen Eye Vision requires that my portion is paid at the time services are rendered unless other arrangements are made in advance. Accounts 90 days old may be subject to collection fees. There will be a service charge on all returned checks.

Payment from my insurance is to be paid directly to Keen Eye Vision. 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 _____

Keen Eye Vision

PATIENT HISTORY AND INFORMATION

HEALTH HISTORY

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

When was your last health exam ? _____

Current Medications: _____

Current Eye Drops: _____

Past Eye Surgeries/ Injuries: _____

Specific Allergies(Medications/Seasonal): _____

GENERAL HEALTH CONDITION

Are you experiencing problems with or have you been diagnosed with any of the following?

Fever	<input type="radio"/> Yes <input type="radio"/> No
Anxiety or Depression	<input type="radio"/> Yes <input type="radio"/> No
Weight Loss	<input type="radio"/> Yes <input type="radio"/> No
Cardiovascular	<input type="radio"/> Yes <input type="radio"/> No
Ears, Nose, Throat	<input type="radio"/> Yes <input type="radio"/> No

Thyroid	<input type="radio"/> Yes <input type="radio"/> No
Diabetes	<input type="radio"/> Yes <input type="radio"/> No
Neurological	<input type="radio"/> Yes <input type="radio"/> No
Skin Condition	<input type="radio"/> Yes <input type="radio"/> No
Muscles, Bones, Joints	<input type="radio"/> Yes <input type="radio"/> No

Respiratory (Asthma)	<input type="radio"/> Yes <input type="radio"/> No
Gastrointestinal	<input type="radio"/> Yes <input type="radio"/> No
Kidney Disease	<input type="radio"/> Yes <input type="radio"/> No
Blood/Lymph	<input type="radio"/> Yes <input type="radio"/> No
Pregnant/Nursing	<input type="radio"/> Pregnant <input type="radio"/> Nursing

EYE HISTORY

Are you experiencing problems with or have you been diagnosed with any of the following?

Glaucoma	<input type="radio"/> Yes <input type="radio"/> No
Cataract	<input type="radio"/> Yes <input type="radio"/> No
Macular Degeneration	<input type="radio"/> Yes <input type="radio"/> No
Retinal Detachment	<input type="radio"/> Yes <input type="radio"/> No
Color Blindness	<input type="radio"/> Yes <input type="radio"/> No

Strabismus (eye turn)	<input type="radio"/> Yes <input type="radio"/> No
Dryness	<input type="radio"/> Yes <input type="radio"/> No
Tearing	<input type="radio"/> Yes <input type="radio"/> No
Itching	<input type="radio"/> Yes <input type="radio"/> No
Amblyopia	<input type="radio"/> Yes <input type="radio"/> No

Blurred Distance Vision	<input type="radio"/> Yes <input type="radio"/> No
Blurred Near Vision	<input type="radio"/> Yes <input type="radio"/> No
Floaters	<input type="radio"/> Yes <input type="radio"/> No
Tired Eyes	<input type="radio"/> Yes <input type="radio"/> No
Double Vision	<input type="radio"/> Yes <input type="radio"/> No

FAMILY HISTORY

Amblyopia	<input type="radio"/> Yes <input type="radio"/> No
Blindness	<input type="radio"/> Yes <input type="radio"/> No
Cataract(s)	<input type="radio"/> Yes <input type="radio"/> No
Color Blindness	<input type="radio"/> Yes <input type="radio"/> No
Glaucoma	<input type="radio"/> Yes <input type="radio"/> No
Macular Degeneration	<input type="radio"/> Yes <input type="radio"/> No

Retinal Detachment	<input type="radio"/> Yes <input type="radio"/> No
Strabismus	<input type="radio"/> Yes <input type="radio"/> No
Arthritis	<input type="radio"/> Yes <input type="radio"/> No
Cancer	<input type="radio"/> Yes <input type="radio"/> No
Diabetes	<input type="radio"/> Yes <input type="radio"/> No
Heart Disease	<input type="radio"/> Yes <input type="radio"/> No

High Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No
Kidney Disease	<input type="radio"/> Yes <input type="radio"/> No
Lupus	<input type="radio"/> Yes <input type="radio"/> No
Stroke	<input type="radio"/> Yes <input type="radio"/> No
Thyroid Disease	<input type="radio"/> Yes <input type="radio"/> No
Others	<input type="radio"/> Yes <input type="radio"/> No

Primary Health Doctor _____

Phone _____

SPECIAL EYEWEAR NEEDS

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

Name _____

Keen Eye Vision

SOCIAL HISTORY

Current Occupation : _____ Years: _____ Employer: _____

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 recreational Drugs : Yes No

Hobbies/ Interests : _____

SPECTACLE LENS HISTORY

Do you currently wear glasses ? Yes No If Yes,What for? FullTime PartTime Distance Close

Glasses Owned? SingleVision Progressive(no-line) Bifocals Trifocals Backup Safety Sports

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

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

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 wear sunglasses? Yes No Are your sunglasses prescription ? Yes No

CONTACT LENS HISTORY

Do you currently wear contact lenses? Yes No If Yes,are they hard or soft? _____

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

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

What Solutions do you use? _____

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