ROBERTS EYECARE ASSOCIATES

PATIENT HISTORY

Name _____ Today's Date _____

Preferred Phone # _____ Date of Birth _____

General Health Conditions _____

_____

_____

Current Medications / Vitamins / Supplements _____

_____

_____

Date of last eye exam if not in our office _____ Doctor _____

Marital Status ❑ Single ❑ Married ❑ Partnered ❑ Widowed ❑ Divorced ❑ Separated

Check Any Symptoms That Apply to You:

❑ Blurred Distance Vision	❑ Flashing Lights	❑ Floaters or Spots	❑ Itchy Eyes
❑ Blurred Near Vision	❑ Frequent or Severe Headaches	❑ One Eye Turns	❑ Red Eyes
❑ Distorted Vision	❑ Temporary Blindness	❑ Eyes Burn	❑ Diabetic
❑ Double Vision	❑ Watery Eyes	❑ Dry Eyes	❑ Insulin Dependent
❑ Eye Pain	❑ Halos Around Lights	❑ Eye Injury	❑ High Blood Pressure
			❑ _____

Do you have any allergies?

❑ Yes ❑ No If yes, please print _____

Are you allergic to any medications?

❑ Yes ❑ No If yes, please list _____

Do you have or have you previously been diagnosed with any eye diseases or had any eye surgery?

❑ Yes ❑ No If yes, explain _____

Is there any family history of: ❑ Diabetes ❑ Cataracts ❑ Glaucoma ❑ Macular Degeneration

Other _____

Do you smoke? ❑ Yes ❑ No If yes, How much? _____

Do you use any substances (alcohol or illegal drugs) that may affect your health? ❑ Yes ❑ No

If so, describe _____

Have you stopped wearing contact lenses due to comfort or vision? ❑ Yes ❑ No ❑ N/A

Are you interested in: Wearing contact lenses/colors? ..... ❑ Yes ❑ No

Wearing Bifocal contact lenses? ..... ❑ Yes ❑ No

NOTES OR QUESTIONS TO THE DOCTOR _____

_____

PLEASE TURN OVER FOR ADDITIONAL INFORMATION **(OVER)**

What were the factors that affected your decision to choose our office? (check any that apply):
❑ Doctor's Reputation ❑ Community Involvement ❑ Friend/Relative ❑ Newspaper ❑ TV ❑ Radio ❑ Yellow Pages
❑ Accept my Insurance ❑ Location ❑ Other _____

Pupillary Dilation: Dilation of the pupil involves drops in the eyes, which temporarily enlarges the pupils. This allows the Doctor to see more of your central and peripheral retina. A common temporary effect of the eye drops is difficulty reading and light sensitivity. Driving may be more difficult when dilated. Dilation usually wears off in 1 to 6 hours and increases your time in our office by an additional 30 minutes. **I Request Dilation**_____ **I Refuse Dilation** _____
Our office provides spectacle lenses that meet or exceed American National Standards Z80. 1/Z87.1 and FDA regulations 21 CFR 801.410 for impact resistance. No lens material today is unbreakable or shatterproof. Of all the materials that lenses are made from, Polycarbonate, Plastic and Glass, **POLYCARBONATE HAS BEEN RECOGNIZED AS THE MOST IMPACT RESISTANT.**

Please list any activities or visual needs that may require additional attention (I.E. sports, computer terminals (VDT), hazardous occupations or hobbies) _____

May we contact your primary care physician with any test results? ❑ Yes ❑ No Physician _____

Female Patients: Are you pregnant? ❑ Yes ❑ No ❑ Unsure Are you breast feeding? ❑ Yes ❑ No
Please identify if applicable: **Optical Insurance:** _____(routine eye exam, frame, lenses and/or contact lenses)
Major Medical Insurance: Primary _____ Secondary _____

All insurance coverage must be presented and identified at time of service. Failure to do so may result in non-coverage or denial by your insurance company, making you responsible for any non-covered charges or services rendered.
It is your responsibility to know your insurance coverage and eligibility at time of service to qualify for any coverage or discounts. We will not ask. All co-pays and overages are due in full at time of order or service.

Contact Lens fitting, evaluation and management fees are not included as part of your comprehensive eye exam.

If your account or any account you are responsible for is turned over for collection, you will be responsible for any and all collection and/or attorney fees. Should your check have to be reprocessed by the bank, there is a $20 reprocessing fee. If your check is returned for insufficient funds there is a $20 returned check fee.

We are not responsible for any frames, lenses or contact lenses that are not picked up within 60 days.

I accept financial responsiblity for any unpaid balance not covered by my vision care or major medical for services rendered to myself and/or my dependents. I also authorize the release of any information relating to this claim.

Patient or Parent/Guardian Signature (required)_____

May we contact you via e-mail: ❑ Yes ❑ No If yes, list _____