(This form must be updated at every visit)

PATIENT INFORMATION ☐ NEW PATIENT ☐ PREVIOUS PATIENT

Last Name_____ First Name_____ M.I._____

Preferred name_____ Birthdate _____ ☐Male ☐Female

Address_____ Apt/Unit #_____

City_____ State_____ ZIP_____

SSN_____ Employer/School_____ Occupation/Grade _____

Primary Phone: ☐Cell ☐Home _____Secondary Phone: ☐Cell ☐Home_____

Email Address_____ Communication Preference: ☐E-mail ☐Text ☐Call ☐Postal

Preferred Language_____Race_____Ethnicity_____

Marital Status: ☐Single ☐Married ☐Other_____ Spouse (or Parent's) Name_____

Spouse (or Parent's) Birthdate_____ Spouse (or Parent's) Phone _____

How did you hear about our clinic? For whom may we thank? _____

PURPOSE OF TODAY'S VISIT

☐ Routine Eye Exam ☐ Contact Lens Fitting ☐ Update Glasses ☐ Refractive Surgery (LASIK) Evaluation

☐ Diabetic Eye Exam ☐ Other _____ **Date of Last Eye Exam** _____

MEDICAL AND EYE HISTORY

Do you or any family members have/had any of the following?

Heart Disease ☐ Self ☐ Family, who? _____ Allergies ☐ Self ☐ Family, who? _____

High Blood Pressure ☐ Self ☐ Family, who? _____ Cancer ☐ Self ☐ Family, who? _____

High Cholesterol ☐ Self ☐ Family, who? _____ Cataracts ☐ Self ☐ Family, who? _____

Inherited Diseases ☐ Self ☐ Family, who? _____ Diabetes ☐ Self ☐ Family, who? _____

Macular Degeneration ☐ Self ☐ Family, who? _____ Glaucoma ☐ Self ☐ Family, who? _____

Any other **Eye Problems**/Surgeries: ☐ Self _____ ☐ Family, who? _____

Any Other Health Problems: ☐ Self _____☐ Family, who? _____

Women: Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Did you have **LASIK**? ☐ Yes, when?_____ ☐ No If no, are you interested? ☐ Yes ☐ No

List any **medications** you are taking_____

Allergies to medicines_____

Name of primary physician_____ Date of last physical check-up_____

Please go to next page to complete.

SOCIAL HISTORY

Do you drive? ☐ No ☐ Yes If yes, do you have difficulty with vision while driving? ☐ No ☐ Yes

Do you use cigarettes/tobacco/other drugs? ☐ No ☐ Yes - type/amount/how long:_____

Do you drink alcohol? ☐ No ☐ Yes - type/amount/how long:_____

What type of hobbies or sport activities do you do?_____

Do you have any special vision requirements relating to hobbies/sports/special activities? _____

_____

Are you satisfied with your current pair of glasses? ☐ No ☐ Yes ☐ N/A Do you have a pair of prescription sunglasses? ☐ No ☐ Yes

How many hours are you on the computer per day? _____ Do you have a pair of computer glasses? ☐ No ☐ Yes

Do you wear contact lenses? ☐ No ☐ Yes, type: ☐ Soft ☐ Conventional ☐ Hard/Gas Permeable ☐ Disposable

Which brand of contacts do you currently wear? _____

How often do you change lenses? _____ How often do you sleep in your contacts? _____

Are you interested in trying contact lenses (or updating your contact lens fitting)? ☐ No ☐ Yes

Are you interested in trying Dailies or Color Contacts? ☐ No ☐ Yes _____

INSURANCE INFORMATION

Vision Insurance Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Dependent ☐ Other

Name of Insurance_____ ID #_____ Group #_____

Primary Member's Name_____ Primary Member's D.O.B._____

Medical/Secondary Insurance Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Dependent ☐ Other

Name of Insurance_____ ID #_____ Group #_____

Secondary Member's Name_____ Secondary Member's D.O.B._____

I hereby authorize payment of my insurance benefits to I Care Optical. I understand **I am financially responsible for any charges, whether or not paid by said insurance. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to I Care Optical on date of service.** If my insurance does not pay I am responsible for paying all charges of my visit, including contact lens fitting. I authorize I Care Optical to release any information required to process any and all claims for reimbursement on my behalf. A copy of this authorization may be used in place of the original.

Print Name (If minor, of Parent/Guardian's)_____

Patient Signature (If minor, of Parent/Guardian's)_____ **Date**_____

Please go to the next form.