1. Patient Information

○ New Patient ○ Previous Patient

Last Name: First Name: M.I.: Birthdate:

Nickname: Gender: ○ Male ○ Female

Street Address: Apt./Unit #: City: State: Zip Code:

SSN: Employer/School: Occupation/Grade:

Primary Phone: ○ Cell ○ Home Secondary Phone: ○ Cell ○ Phone

Email Address: Communication Preference: ○ E-mail ○ Text ○ Call ○ Postal

2. Purpose of Today's Visit

☐ Routine Eye Exam ☐ Contact Lens Fitting ☐ Update Glasses

☐ Diabetic Eye Exam ☐ Other

If other, specify:

3. Date of Last Eye Exam:

4. Medical and Eye History: Do you or any family members have/had any of the following?

	Self	Family	Who?
Diabetes			
High Cholesterol			
Glaucoma			
High Blood Pressure			
Cataracts			
Macular Degeneration			
Keratoconus			

5. Any other Health/Eye Problems/Surgeries:

6. List any medications you are taking:

	Medication Name	Dosage	Frequency	Reason for Use
1				
2				
3				

7. Allergies to Medicine:

_____

_____

_____

_____

8. Do you wear contact lenses? ○ Yes ○ No

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 prescription)?
○ Yes ○ No

Insurance Information

9. Vision Insurance - Relationship to Subscriber:
○ Self ○ Spouse ○ Dependent ○ Other

Insurance Name: _____ ID #: _____ Group #: _____

Primary Member's Name: _____ Primary Member's DOB: _____

10. Medical/Secondary Insurance - Relationship to Subscriber:
○ Self ○ Spouse ○ Dependent ○ Other

Insurance Name: _____ ID #: _____ Group #: _____

Secondary Member's Name: _____ Secondary Member's DOB: _____

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.

11. Patient (If minor, of Parent/Guardian's) Name:

_____

Patient (If minor, of Parent/Guardian) Signature:

_____

Signature