THE EYE SITE, PLLC
FAMILY EYE CARE & VISION THERAPY CENTER

Today's Date_____

Patient Information

Subscriber DOB_____

Name_____
DOB_____Age_____
Sex: M F
Address_____
City_____State_____
Zip_____
Cell phone_____
Home phone_____
Work phone_____
Patient's SSN_____
Employer/School_____
Occupation/Grade_____
Spouse/Parent's Name_____
Spouse/Parent's Occupation_____
E-mail address_____
Preferred contact method:
Cell Home Work E-mail Text

What is the major purpose of your visit?

_____

Are there any problems with your current contact lenses or glasses? _____

_____

_____

Insurance Information

Vision Plan_____
Subscriber Name_____
Subscriber SSN_____
Subscriber DOB_____

Primary Medical Insurance_____
Subscriber Name_____
Subscriber SSN_____
Subscriber ID#_____

HIPAA Privacy Rule

Due to HIPAA privacy rule, we ask that you list the person(s) to whom we may release your protected health information pertaining to your medical care other than yourself, any doctor or staff involved in your care, and your insurance company.

Name_____Relationship_____
Name_____Relationship_____
Name_____Relationship_____

Patient Eye History

Have you ever experienced, been diagnosed, or treated for any of the following? (Check all that apply)

__Blurry Vision
__Burning
__Cataracts
__Corneal Abrasions
__Crossed eyes/eye turn
__Double Vision
__Eye Infection
__ Eye Injury
__Flashes of Light
__Floaters/Spots
__Glaucoma
__Grittiness
__Headaches
__Iritis/Uveitis
__Itchiness
__Lazy Eye
__Macular Degeneration
__Occasional Dryness
__Retinal Detachment
__Sunlight Sensitivity
__Tearing
__Poor Night Vision
__Uncomfortable glasses

Do you drive? Y N
Do you work at a computer? Y N

_____

Date of last eye exam_____
By whom?_____
Do you wear contact lenses? Y N
If no, would you like to try contact lenses? Y N

Are you interested in laser vision correction, such as LASIK? Y N

Whom may we thank for referring you to our office?

_____

Patient Medical History

Primary Care Physician_____

Date of Last Check-Up_____

Current Medications (please include Rx and OTC medications)_____

_____

_____

_____

Allergies_____

_____

Surgeries_____

_____

Are you pregnant? Y N

Are you nursing? Y N

Do you use cigarettes/tobacco? Y N

Have you ever been diagnosed or treated for the following health problems? (check all that apply)

__Diabetes Type_____
__High blood pressure
__Thyroid Hypo/Hyper
__Heart Disorders
__Stroke
__Heart Attack
__Cancer Type_____
__Ear/Nose/Throat (allergies)
__High cholesterol
__Respiratory
__Kidney
__Digestive
__Endocrine
__Eczema
__Rosacea
__Neurological
__Psychological
__Arthritis Osteo/Rheumatoid
__Lupus
__Sjogren's

Family Eye/Medical History

Is there any family medical history of any of the following? (Check all that apply and give relationship, if known)

__Blindness_____
__Cataracts_____
__Corneal Problems_____
__Diabetes_____
__Glaucoma_____
__Heart Disease_____
__Lazy Eye/Eye Turn_____
__Macular Degeneration_____
__Retinal Problems_____

-I acknowledge that the information given is true to the best of my knowledge. I received a copy of The Eye Site's Notice of Privacy Practices.

-I understand that I am financially responsible for today's services, including any deductibles, co-insurance, and non-covered services.

Signature:_____

Date:_____

Dr. Mosburg and The Eye Site staff appreciate you purchasing your glasses and contact lenses from our office. However, we understand that glasses and contact lenses can be a major financial investment. If you have special budget concerns, please let us know. It is our job to help you get the most out of your glasses and lenses while staying within your budget.

THE EYE SITE, PLLC

FAMILY EYE CARE & VISION THERAPY CENTER

Today's Date_____

We are happy to give you a copy of your glasses or contact lens prescription; however we cannot guarantee the accuracy or quality of products purchased outside of our office.