Riverton

Family EYE Care

Focused on you and your family

WELCOME TO OUR OFFICE

Today's Date _____

Patient Information

Last Name _____
First Name _____ MI _____
Address _____
City _____ State _____
Zip Code _____
Home Phone _____
Work/Cell Phone _____
Patient's SSN _____
Employer/School _____
Occupation/Grade _____
Date of Birth _____ Age _____
Sex ☐ Male ☐ Female (Pregnant ☐ Yes ☐ No)
Marital Status ☐ Single ☐ Married ☐ Other
Spouse (or Parent's) Name _____
Spouse (or Parent's) Work _____
Email Address _____

What is the major purpose of this visit?

_____

Any problems with your current contact lenses or eye glasses? _____

_____

VERY IMPORTANT! NEW PATIENTS ONLY:
Whom may we thank for referring you to our office?
Name of friend or relative _____

If not referred, how did you choose our office?
☐ Another Doctor
☐ Insurance List
☐ Sign/Building
☐ Newspaper/Insert/Flyer/Magazine
☐ Yellow Pages: Which directory? _____
☐ Web Page: Which Web Site? _____
☐ Other _____

The mission of Riverton Family Eye Care is commitment to you and your family's lifetime eye health care by providing the highest quality care in both services and products, focusing on each patient's eye care needs, maximizing patient education to understand all aspects of their vision and eye health, and promoting a comfortable, fun, and enjoyable eye care experience. Your visual needs, wellness, and quality of life will always be our first priority.

Insurance Information

Vision Insurance _____
Subscriber Name _____
Subscriber SSN _____ DOB _____
Patient Relationship to Subscriber _____

Primary Medical Insurance _____
Subscriber Name _____
Subscriber SSN _____
Subscriber DOB _____

Do you participate in a flex spending account?
☐ Yes ☐ No
How will you settle your account today?
☐ Credit Card ☐ Debit Card
☐ Cash ☐ Check

Lifestyle Questions

Do you..... (check box if your answer is yes)
☐...work at a computer? If yes, please complete computer questionnaire.
☐...think you might benefit from thinner, lighter lenses?
☐...have interest in a "test drive" of the latest contact lens designs.
☐...spend time outdoors? How much? ___ Hrs/week.
☐...have prescription sunwear?
☐...prefer not to wear your glasses at times?
☐...want information on Laser Vision Correction
☐...have interest in a non-surgical approach to vision correction?
☐...have more than 1 pair of current Rx eyewear?
☐...have children?
☐...have family members in need of eyecare?

Have you ever experienced, been diagnosed or treated for any of the following?

☐ Blurry Vision	☐ Burning
☐ Crossed eye/Eye turn	☐ Cataracts
☐ Eye Infections	☐ Corneal Abrasions
☐ Flash of light	☐ Double Vision
☐ Glaucoma	☐ Eye Injury
☐ Sunlight Sensitivity	☐ Floaters/Spots
☐ Trouble seeing at night	☐ Grittiness
☐ Macular Degeneration	☐ Iritis/Uveitis
☐ Retinal Detachment	☐ Lazy Eye
☐ Occasional dryness	☐ Tearing
☐ Uncomfortable glasses	☐ Headaches
☐ Other eye disorders	☐ Itchiness

_____

The information in this confidential case history form is critical to the evaluation of your vision and health.

Patient Medical History

Name of Family Physician _____
City _____
Date of Last Physical Check-up _____

CURRENT MEDICATIONS (Rx or Over the Counter)
(List name of medications including eye drops, vitamins, & birth control pills)

_____
_____
_____

Allergies to medications? ☐ Yes ☐ No
If so, what medications? _____
_____

Have you had any surgeries? ☐ Yes ☐ No
Do you use cigarettes/tobacco, alcohol, or other substances?
☐ Yes ☐ No

Have you ever been diagnosed or treated for the following health problems?	**Yes**	**No**
Allergies	☐	☐
Arthritis	☐	☐
Blood/Lymph	☐	☐
Bronchitis	☐	☐
Cancer	☐	☐
Cholesterol	☐	☐
Diabetes	☐	☐
Digestive	☐	☐
Ears/Nose/Throat	☐	☐
Endocrine	☐	☐
Eczema/Rashes	☐	☐
Fatigue	☐	☐
Fevers	☐	☐
Genitourinary	☐	☐
High Blood Pressure	☐	☐
Integumentary (Skin)	☐	☐
Kidney	☐	☐
Muscle/Bone	☐	☐
Neurological	☐	☐
Psychological	☐	☐
Respiratory	☐	☐
Sinus Throat Infections	☐	☐
Thyroid	☐	☐
Unusual weight losses/gains	☐	☐

Patient Eye History

Date of Last Eye Exam _____
By Whom? _____

Have you ever tried contact lenses? ☐ Yes ☐ No

Do you currently wear contact lenses? ☐ Yes ☐ No

What kind? _____
Solutions used. _____

Are you satisfied with the vision and comfort of your contact lenses? ☐ Yes ☐ No

Would you prefer clear contact lenses or colored contact lenses? ☐ Clear ☐ Colored

If you wear bifocals, do the lines or head tilting bother you? ☐ Yes ☐ No

Family Medical/Eye History (Check all that apply)

Is there a family medical history of any of the following:
☐ No ☐ Yes (Please check boxes)

		Relationship (Mother's or Father's side)
Blindness	☐	_____
Cataracts	☐	_____
Corneal Problems	☐	_____
Diabetes	☐	_____
Glaucoma	☐	_____
Heart Disease	☐	_____
Lazy Eye	☐	_____
Macular Degeneration	☐	_____
Retinal Problems	☐	_____

Many of the above problems are detected by viewing the back of the eye. This retinal exam is a necessary part of the eye health check. This may require dilation or retinal photos at an additional $15.00 charge.

Please be advised if you are using insurance coverage for today's visit, this is a contract between you and your insurance company . . . . . not Riverton Family Eyecare.

If your insurance company has not reimbursed our office in full within 90 days, you will be sent a statement for the balance due. (If by mistake your insurance company sends the payment or check to us, we will of course forward a check in that same amount to you.)

Signature _____