Welcome to Eye Connection Optical

Date: _____Name: _____
D.O.B.:_____Occupation:_____
Email Address_____
Address: _____
City, State, Zip Code: _____
Phone: (Home) _____(Cell)_____(Work)_____
Marital Status: Married ☐ Single ☐ Widow ☐ Minor (under 18yrs. Old) ☐

Reason for visit: Glasses _____ Contact Lenses_____ Other _____

Method of payment: Cash ☐ Credit/Debit Card ☐ Check ☐ Insurance ☐ CareCredit ☐

Patient Medical History

Date of Last Eye Exam: _____Name of Doctor: _____
Name of Medical Doctor: _____Date of Last Visit: _____

Please mark Yes or No for each condition

Burning/Watery Eyes	☐	Yes	No ☐	Arthritis	☐	Yes	No ☐
Cataracts	☐	Yes	No ☐	Asthma/Lung Problems	☐	Yes	No ☐
Crossed Eye(s)	☐	Yes	No ☐	Cancer	☐	Yes	No ☐
Double Vision	☐	Yes	No ☐	Diabetes	☐	Yes	No ☐
Dry Eyes	☐	Yes	No ☐	Frequent Headaches	☐	Yes	No ☐
Eye Injury/Surgery	☐	Yes	No ☐	Heart Attack/Heart Disease	☐	Yes	No ☐
Floaters	☐	Yes	No ☐	Head Trauma	☐	Yes	No ☐
Glaucoma	☐	Yes	No ☐	Hepatitis(Type____)	☐	Yes	No ☐
Itchy Eyes	☐	Yes	No ☐	High Blood Pressure	☐	Yes	No ☐
Lazy Eye	☐	Yes	No ☐	High Cholesterol	☐	Yes	No ☐
Macular Degeneration	☐	Yes	No ☐	Kidney Disease	☐	Yes	No ☐
Ocular Trauma	☐	Yes	No ☐	Migraine Headaches	☐	Yes	No ☐
Retinal Tear/Detachment	☐	Yes	No ☐	Stroke	☐	Yes	No ☐
Seasonal Allergies	☐	Yes	No ☐	Thyroid condition	☐	Yes	No ☐
AIDS/HIV	☐	Yes	No ☐	Tuberculosis	☐	Yes	No ☐
Abnormal Bleeding	☐	Yes	No ☐	Other:	☐	Yes	No ☐

Are you pregnant? Y/N ☐ Tobacco Use? Y/N ☐ Alcohol Use? Y/N ☐

FAMILY HISTORY

Glaucoma	Y/N	Which Relative:	Diabetes	Y/N	Which Relative:
Cataracts	Y/N	Which Relative:	High Blood Pressure	Y/N	Which Relative:
Lazy Eyes	Y/N	Which Relative:	Macular Degeneration	Y/N	Which Relative:

Medications

Please List any medications you are currently taking (includes eye drops):

_____

Allergies

Please list any allergies to medication or other substances:

_____

Vision Insurance (PLEASE COMPLETE ONLY IF USING INSURANCE)

Name of Insurance Plan:_____Name of Insured:_____
Employer:_____Patient I.D.# or Insured SSN#:_____

Privacy Policy

Your information must be kept confidential due to laws known as HIPPA. Please sign below stating that you have read our privacy practices.
I have received and been provided with an opportunity to read over the Privacy Practices.
Signature(Guardian if Minor)_____Date:_____

Dilation

Pupil dilation allows the doctor to examine the internal health of your eyes; it is recommended. The drops will cause blurred near vision and light sensitivity for 3-4 hours.

"Distance vision is USUALLY Not affected significantly."

This eye doctor examines the structures of the eyes, including the optic nerve, blood vessels and retina, in great detail. Dilation is a key component of a comprehensive eye examination, as it sometimes leads to the detection and diagnosis of certain eye diseases.

I understand the importance of Pupillary Dilation.
I do☐ or do not☐ give my permission for diagnostic drops to be administered to my eyes.

Signature: _____Date:_____

Assignment and Release

I authorize my insurance company to pay directly to the eye doctor and/or supplier benefits otherwise payable to me for services rendered.

The doctor and/or supplier may use my health care information and may disclose such information to the above named insurance company for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This signature is good for one year from date signed below.

Signature of Patient, Guardian, or Parent: _____Date:_____

Print Form