

WELCOME TO MT. STERLING EYECARE

We are so pleased that you have entrusted your eye care to us. Please take a few moments to fill out the following information so that we may best meet your needs. Please print all information.

Patient Information

Name _____ SS# _____ Date _____
(first) (middle initial) (last)

By what name do you prefer to be addressed? _____

Address _____
(street) (city) (state) (zip)

Birthdate _____ Email _____

Home Phone () _____ Cell Phone () _____ Work Phone () _____

Do you prefer to receive calls at Home Cell Work No preference

Patient Employer or School _____ Occupation or Grade _____

Employer or School Address _____
(street) (city) (state) (zip)

Spouse or Parent's Name _____ Employer _____ Work Phone _____

Whom may we thank for referring you to us? _____

Responsible Party

Name of person responsible for this account _____

Relationship to patient _____ Phone Number _____

Address _____
(street) (city) (state) (zip)

Employer _____ Work Phone () _____

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security Number _____ Date Employed _____

Name of Employer _____ Work Phone () _____

Address _____
(street) (city) (state) (zip)

Vision Insurance Co. _____ Member ID _____ Group # _____

Insurance Co Address _____
(street) (city) (state) (zip)

Medical Insurance Co. _____ Member ID _____ Group # _____

Insurance Co Address _____
(street) (city) (state) (zip)

When making a third party claim, I authorize Mt. Sterling EyeCare to bill the insurance company on my behalf for any covered charges. I authorize the release of any medical information necessary for processing the claim. I also authorize my insurance company to pay Mt. Sterling EyeCare directly. I understand I am responsible for any amount not covered.

Patient or Parent Signature _____ Date _____

Health and Vision History

Date of last vision exam _____ Name of Doctor _____

Date of last physical exam _____ Name of Doctor _____

Does any blood relative have any of the following conditions?

Diabetes	yes	no	Macular Degeneration	yes	no
Glaucoma	yes	no	Lazy Eye	yes	no
Cataract	yes	no	Blindness	yes	no
Migraine headaches	yes	no	Heart Disease	yes	no

Are you currently receiving treatment from a physician? yes no

Have you recently had any illness? yes no

Are you presently taking or using any medication? yes no

(Women) Are you pregnant or nursing? yes no

Do you use any of the following products?

Tobacco?	yes	no
Alcohol?	yes	no
Recreational drugs?	yes	no

Do you currently wear glasses? Yes No

If yes, () All the time () For reading only () For computer only () For driving only

Do you currently wear contact lenses? Yes No

If not, are you interested in wearing them? Yes No

If yes, how often do you replace your lenses?

() 1 day () 1 week () 2 weeks () 1 month () 2 months () 3 months () 6 months () 1 year

How much time per day do you spend on a computer?

() none () 1 hr () 2hrs () 3hrs () 4 hrs () 5 hrs () 6 hrs () 7 hrs () 8 hrs () more

Do you have headaches or eyestrain during or after computer work? Yes No

Have you ever had any problems with the following?

Eyes	Yes	No	Constitutional symptoms	Yes	No	Hematologic/Lymphatic	Yes	No
Blindness or vision loss	Yes	No	Fever	Yes	No	Anemia	Yes	No
Blurred vision	Yes	No	Weight loss	Yes	No	Bleeding problems	Yes	No
Double vision	Yes	No	Cardiovascular			Swelling	Yes	No
Eye irritation	Yes	No	Heart pain	Yes	No	Integumentary		
Eye pain	Yes	No	High blood pressure	Yes	No	Skin	Yes	No
Tired eyes	Yes	No	Vascular disease	Yes	No	Breast	Yes	No
Crossed eyes	Yes	No	Ear, Nose, Mouth, Throat			Musculoskeletal		
Flashes of light in vision	Yes	No	Allergies/hay fever	Yes	No	Arthritis	Yes	No
Floater in vision	Yes	No	Sinus problems	Yes	No	Rheumatoid arthritis	Yes	No
Dry eyes	Yes	No	Chronic cough	Yes	No	Muscle pain	Yes	No
Watery eyes	Yes	No	Dry mouth	Yes	No	Joint pain	Yes	No
Red eyes	Yes	No	Chronic ear infections	Yes	No	Neurological		
Mucous discharge	Yes	No	Endocrine			Headaches	Yes	No
Glare	Yes	No	Diabetes	Yes	No	Migraines	Yes	No
Light sensitivity	Yes	No	Thyroid problems	Yes	No	Seizures	Yes	No
Eye Surgery	Yes	No	Other glands	Yes	No	Psychiatric		
Eye Injury	Yes	No	Gastrointestinal			Nervous disorders	Yes	No
Retinal Detachment	Yes	No	Diarrhea	Yes	No	Depression	Yes	No
Glaucoma	Yes	No	Constipation	Yes	No	Compulsive behavior	Yes	No
Macular Degeneration	Yes	No	Ulcers	Yes	No	Respiratory		
Allergic Immunologic			Genitourinary			Asthma	Yes	No
Hay fever	Yes	No	Kidneys	Yes	No	Shortness of breath	Yes	No
Drug allergies	Yes	No	Bladder	Yes	No	Emphysema	Yes	No
						Lung cancer	Yes	No

Eyewear

- If you wear glasses, check any lens features that are on your old glasses

() thin and lite lenses () anti-reflective lens () lenses that change color () rolled and polished edges
 () no-line bifocals () prescription sunglasses () ultraviolet block

- Indicate which features you are interested in for your new glasses

() thin and lite lenses () anti-reflective treatment () lenses that change color () rolled and polished edges
 () no-line bifocals () prescription sunglasses () ultraviolet block