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			**Constitutional symptoms**			**Hematologic/Lymphatic**		
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
Floaters 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**		
			Genitourinary			Asthma	Yes	No
Allergic Immunologic			Kidneys	Yes	No	Shortness of breath	Yes	No
Hay fever	Yes	No	Bladder	Yes	No	Emphysema	Yes	No
Drug allergies	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