Carson Eye Care Optometry, Inc.

Welcome to our office. Please print the following information: Date: ______________________

Patient's Name: ______________________ Email: ______________________

Address: ______________________ Home Phone: ( ) _______-_______

City, State, Zip: ______________________ Cell / Work Phone: ( ) _______-_______

Age: __________ Date Of Birth: ______________ Patient's Social Security #: ______________

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Please indicate method of payment: _____CASH ____CHECK _____CREDIT CARD _____INSURANCE

If you have insurance, please fill out the following: Name of Primary Insured: ______________________

Group Number: ______________________ Insured's Date of Birth: ______________________

Insured's ID/Social Security #: ______________ Name of Employer: ______________________

Name of Insurance: ______________________

I hereby authorize any person/institution rendering care to furnish all facts concerning this claim. I authorize payment for my vision benefits to go directly to Carson Eye Care Optometry. I agree that if my employer, insurance carrier or plan sponsor denies payment to all or any portion of my claim, I will be financially responsible for all outstanding charges. Authorization obtained at time of service does not guarantee payment.

Patient or Guardian Signature: ____

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Please indicate the reasons for visiting our office today:

- ☐ General Check Up
- ☐ Lost or Broken Glasses
- ☐ Want New Glasses
- ☐ Want Thinner/Lighter Glasses
- ☐ Want Sunglasses
- ☐ Want Contact Lenses
  - ☐ Soft ☐ RGP/Hard Contact Lens
  - ☐ Disposable ☐ Non Disposable
  - ☐ Clear ☐ Colored
  - ☐ Bifocal ☐ Toric ☐ Other ______________
- ☐ Problems with Present Contact Lenses
- ☐ Blurred Distance Vision
- ☐ Trouble Seeing at Night
- ☐ Computer Eye Strain
- ☐ Blurred Near Vision
- ☐ Headaches
- ☐ Eyes Feel Tired
- ☐ Eyes Feel Dry
- ☐ Eyes Itch
- ☐ Eyes Water
- ☐ Eyes Burn
- ☐ Other (please explain):______________

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When was your last eye exam (month/year)? ______________

Where was your last eye exam (office name/doctor name)? ______________________ or indicate below

☐ School ☐ DMV ☐ Physician's Office ☐ Mall/Chain Store ☐ Not Sure

How did you hear about us?

- ☐ Friend/Relative ______________________
- ☐ Insurance List
- ☐ Saw Sign
- ☐ Website/Internet
- ☐ Postcard
- ☐ Another Doctor
- ☐ Phone Book
- ☐ Former Patient

Please list all medications you are currently taking or circle NONE

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Do you have any allergies to medications? (Please list all that apply) or circle **NONE**

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Please circle if you have the following conditions or circle **NONE**:

Ocular History:	None		**General Medical History/Review of Systems:**		
Glaucoma	Y	N	High Blood Pressure	Y	N
Macular Degeneration	Y	N	Diabetes	Y	N
Retinal Detachment	Y	N	Cholesterol	Y	N
Retinal Tear/Hole	Y	N	Ears, nose, mouth, throat	Y	N
Amblyopia (lazy eye)	Y	N	Cardiovascular/Heart problems	Y	N
Strabismus (eye turn)	Y	N	Respiratory/ Asthma/ Emphysema	Y	N
Cataracts	Y	N	Gastrointestinal/stomach	Y	N
Blindness	Y	N	Genitourinary/ Kidney/Bladder	Y	N
Eye Infections/Ulcers	Y	N	Musculoskeletal/Arthritis	Y	N
Eye Surgery/Injury	Y	N	Skin/rashes/growths	Y	N
Flashes/Floaters	Y	N	Headaches/migraines	Y	N
Allergies/Hayfever	Y	N	Depression/Anxiety/Insomnia	Y	N
Sinus	Y	N	Endocrine/ Thyroid problems	Y	N
			Lupus	Y	N

Is there anyone in your family that have the above medical/eye conditions:

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Please describe any conditions below if you need more space:

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FOR CONTACT LENS EXAMINATIONS

I understand that my doctor may recommend a follow up visit within 30 days of my initial exam date. There is no charge for this visit within 30 days. After 30 days patients are charged an office visit fee.
Contact Lens Prescriptions will not be released without proper follow up. Only one trial pair of lenses will be permitted per patient. All Contact lens Prescriptions expire in one year. Patient agrees to wear lenses as recommended. Contact lens exam is good for one manufacturers lens to be fit. Any additional lenses are fit for an extra contact lens fee.

Sign____Date____________________

FOR ALL PATIENTS

Carson Eye Care Optometry, Inc. will maintain the privacy of your health information and personal data. Your information will be released only upon your authorization. The law permits us to disclose your information for treatment, payment, and regular health care operations. Examples: Calling to confirm appointments, sending recall cards, referring to doctors for evaluation, pharmacies, opticals and to third party insurance. By signing below, I acknowledge I have received and or read the privacy notice from Carson Eye Care, Inc.

Sign: ____Date____________________