

WELCOME TO FOUNTAIN OPTOMETRY

Patient Information

Today's Date _____

Last _____

First _____ MI _____

Address _____

City _____ State _____

Zip Code _____

Rank in the order you would prefer to be contacted:

___ Home Phone _____

___ Work Phone _____

___ Email _____

___ Cell phone # _____

Date of Birth _____ Age _____

Sex M F Patient's SSN _____

Employer (or School) _____

Occupation (or Grade) _____

Spouse's (or Parent's) Name _____

Spouse's (or Parent's) Work _____

What is the major purpose of this visit?

Any problems with your current contact lenses or glasses?

VERY IMPORTANT! NEW PATIENTS ONLY:

Who may we thank for referring you to our office?
Name of friend or relative _____

If not referred, how did you choose our office?

Another Dr. _____

Insurance List

Saw Sign/Building

Newspaper/Radio/TV

Yellow Pages: Which directory? _____

Web Page: Which Web Site? _____

Other _____

The mission of Fountain Optometry Family Eyecare is to contribute to a lifetime of healthy vision, providing each patient with the highest quality vision care and consequent quality of life. We will seek continuing education to remain at the forefront of our profession and will offer the latest eye care technology, professional services, and products. The visual needs and wellness of each patient will always be our first priority. Everything we do shall communicate this.

Insurance Information

Please note that most insurances do NOT cover the Contact Lens Follow-Up Evaluation.

Vision Insurance _____

Subscriber Name _____

Subscriber ID# _____

Subscriber Birth Date _____

Primary Medical Insurance _____

Subscriber Name _____

Subscriber ID# _____

Subscriber Birth Date _____

Secondary Medical Insurance _____

Subscribers Name _____

Subscribers ID# _____

Lifestyle Questions

Do you.....(check box if your answer is yes)

..work at a computer? If yes, How many hours a day?

..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 surgery?

..have more than 1 pair of current Rx eyewear?

..have children?

..have family members in need of eyecare?

..participate in any sports? _____

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

Blurry Vision

Burning

Cataracts

Corneal Abrasions

Crossed eye/Eye turn

Double Vision

Eye Infections

Eye Injury

Flash of light

Floaters/Spots

Glaucoma

Grittiness

Headaches

Iritis/Uveitis

Itchiness

Lazy Eye

Macular Degeneration

Occasional dryness

Retinal Detachment

Sunlight Sensitivity

Tearing

Trouble seeing at night

Uncomfortable glasses

Other eye disorders _____

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 _____ Town _____ 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, what medications? _____		
Have you had any surgeries? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Is there a chance you are pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Do you use: <input type="checkbox"/> Cigarettes/tobacco <input type="checkbox"/> Alcohol <input type="checkbox"/> Other substances: _____		
Have you ever been diagnosed or treated for the following health problems?		
	Yes	No
Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Blood/Lymph	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Digestive	<input type="checkbox"/>	<input type="checkbox"/>
Ears/Nose/Throat	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine	<input type="checkbox"/>	<input type="checkbox"/>
Eczema/Rashes	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>
Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
HIV	<input type="checkbox"/>	<input type="checkbox"/>
Integumentary (Skin)	<input type="checkbox"/>	<input type="checkbox"/>
Kidney	<input type="checkbox"/>	<input type="checkbox"/>
Muscle/Bone	<input type="checkbox"/>	<input type="checkbox"/>
Neurological	<input type="checkbox"/>	<input type="checkbox"/>
Psychological	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>
Sinus	<input type="checkbox"/>	<input type="checkbox"/>
Throat Infections	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Unusual weight losses/gains	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other _____		

Patient Eye History
Date of Last Eye Exam _____ By Whom? _____
Have you ever tried contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you currently wear contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No What kind? _____ Solutions used _____
Are you satisfied with the vision and comfort of your contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No
Would you prefer clear contact lenses or colored contact lenses? <input type="checkbox"/> Clear <input type="checkbox"/> Colored
If you wear bifocals, do the lines or head tilting bother you? <input type="checkbox"/> Yes <input type="checkbox"/> No
Family Medical/Eye History (Check all that apply)
Is there a family medical history of any of the following: <input type="checkbox"/> No <input type="checkbox"/> Yes (Please check boxes)
Relationship <u>AND</u> state Mother's or Father's side
Blindness <input type="checkbox"/> _____
Cataracts <input type="checkbox"/> _____
Corneal Problems <input type="checkbox"/> _____
Diabetes <input type="checkbox"/> _____
Glaucoma <input type="checkbox"/> _____
Heart Disease <input type="checkbox"/> _____
Lazy Eye <input type="checkbox"/> _____
Macular Degeneration <input type="checkbox"/> _____
Retinal Problems <input type="checkbox"/> _____
I certify that I, and/or my dependent(s), have insurance coverage with _____ Name of Insurance Company(ies)
And assign directly to Fountain Optometry all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Fountain Optometry may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.
Please sign that you have read and understand the above payment policy and Notice of Privacy Practices.
Signature _____