EYESITE OF ANTHEM

WELCOME BACK TO OUR OFFICE

Today's Date _____

Patient Information

Last _____
First _____ MI _____
Street _____
City _____ State _____
Zip Code _____
Home Phone _____
Work Phone _____
Cell Phone _____
Patient's SSN _____
Employer (or School) _____
Occupation (or Grade) _____
Spouse (or Guardian's Name) _____
Spouse (or Guardian's Work) _____
Date of Birth _____ Age _____
Sex **M F**
Email Address _____

Contact in case of emergency:
Name _____
Phone # _____

What is your main purpose of this visit?

_____

Any problems with your current contact lenses or glasses? _____

_____

Mission Statement

The Eyesite of Anthem delivers unsurpassed eye health care and vision needs to our patients by providing exceptional doctors and trained staff that treat each other and each patient with respect, compassion, integrity, and dignity.

We create an environment that enthusiastically satisfies patients through education and premier customer service at all point of contact and making recommendations that will improve their quality of life.

The visual needs and wellness of each patient will be our first priority.

THANK YOU …

Thank you for returning to The Eyesite of Anthem. We appreciate you choosing the professionals at The Eyesite of Anthem to continue caring for your vision needs and eye health. We thank you for the opportunity to serve you and we are happy to see you again!

We value your feedback. Please tell us how we can improve your experience with us.

_____

_____

Patient Eye History

Date of Last Eye Exam _____
By Whom? _____

Do you currently wear glasses? ❑ Yes ❑ No
❑Full Time ❑Distance only ❑Near only ❑Computer
How old are your glasses? _____

Do you currently wear contact lenses? ❑ Yes ❑ No
What kind? _____
Solutions used _____

Are you satisfied with the vision and comfort of your contact lenses? ❑ Yes ❑ No

Would you prefer clear contact lenses or colored contact lenses? ❑ Clear ❑ Colored

If you wear bifocals, do the lines or head tilting bother you? ❑ Yes ❑ No

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

❑ Blurry Vision
❑ Cataracts
❑ Crossed Eye/Eye turn
❑ Eye Infections
❑ Eye Surgery
❑ Flashes of Light
❑ Glaucoma
❑ Headaches
❑ Itchiness
❑ Macular Degeneration
❑ Retinal Detachment
❑ Excessive Tearing
❑ Uncomfortable Glasses
❑ Other Eye Disorders _____
❑ Burning
❑ Corneal Abrasions
❑ Double Vision
❑ Eye Injury
❑ Excessive Irritation
❑ Floaters/Spots
❑ Grittiness
❑ Iritis/Uveitis
❑ Lazy Eye
❑ Occasional Dryness
❑ Sunlight Sensitivity
❑ Trouble Seeing at Night
❑ Loss of Vision

Lifestyle Questions

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

❑..work at a computer? How much? _____ Hours daily
If yes, please complete computer questionnaire.
❑..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 interest in a non-surgical approach to vision correction?
❑..have more than 1 pair of current Rx eyewear?
❑..have children?
❑..have family members in need of eyecare?

Activities (please list):

❑ SPORTS: _____
❑ MUSICAL INSTRUMENTS: _____
❑ HOBBIES: _____

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_____
City_____State_____
Date of Last Physical Check-up_____

CURRENT MEDICATIONS (Rx or Over the Counter)
(List name and dosage of medications including eye drops, vitamins, & birth control pills)_____

_____

_____

_____

Do you have allergies to medications? ❑ Yes ❑ No
If so, what medications?_____

Do you have any other allergies? ❑ Yes ❑ No
If so, please describe _____

Have you had any surgeries? ❑ Yes ❑ No
If so, please list _____

Do you use cigarettes/tobacco, alcohol, or other substances? ❑ Yes ❑ No

Have you ever been diagnosed or treated for the following health problems?	**Yes**	**No**
Allergies	❑	❑
Arthritis	❑	❑
Blood/Lymph	❑	❑
Bronchitis	❑	❑
Cancer	❑	❑
Cholesterol	❑	❑
Diabetes	❑	❑
Digestive	❑	❑
Ears/Nose/Throat	❑	❑
Endocrine	❑	❑
Eczema/Rashes	❑	❑
Fatigue	❑	❑
Fevers	❑	❑
Genitourinary	❑	❑
High Blood Pressure	❑	❑
Integumentary (Skin)	❑	❑
Kidney	❑	❑
Muscle/Bone	❑	❑
Neurological	❑	❑
Psychological	❑	❑
Respiratory	❑	❑
Sinus	❑	❑
Throat Infections	❑	❑
Thyroid	❑	❑
Unusual weight losses/gains	❑	❑

EYESITE OF ANTHEM

Family Medical / Eye History (Check all that apply)

Is there a family medical history of any of the following:
If yes, please describe relationship and if on mother's or father's side)

	Yes		No
Blindness	❑	_____	❑
Cataracts	❑	_____	❑
Corneal Problems	❑	_____	❑
Glaucoma	❑	_____	❑
Lazy Eye	❑	_____	❑
Eye Turn	❑	_____	❑
Macular Degeneration	❑	_____	❑
Retinal Problems	❑	_____	❑
Retinal Problems	❑	_____	❑
Diabetes	❑	_____	❑
Heart Disease	❑	_____	❑
High Blood Pressure	❑	_____	❑
Cancer	❑	_____	❑

Insurance Information

Please note that insurance does NOT cover the Contact Lens Follow-Up Evaluation.

Vision Insurance_____
Subscriber Name_____
Subscriber SSN_____
Subscriber Birth Date_____

Primary Medical Insurance_____
Subscriber Name_____
Subscriber SSN_____
Subscriber Birth Date_____

Do you participate in a flex spending account?
❑ Yes ❑ No
How will you settle your account today?
❑ Cash ❑ Check ❑ Credit Card

Please be advised if you are using insurance coverage for today's visit, this is a contract between you and your insurance company...not Eyesite of Anthem.

If your insurance company has not reimbursed our office in full within 60 (or 90) days, your credit card will be utilized and your insurance company will then pay you directly. (If by mistake your insurance company sends the payment check to us, we will of course sign over and forward the check directly to you.)

Please enter your credit card number and expiration date.
CC#:_____
Expiration Date:_____

Signature_____