

PATIENT INFORMATION FORM (please be as complete as possible)

Full Name _____ Date of Birth _____ Age _____ Today's Date _____

Name you like to be called _____

How did you find out about us? (please circle)

Social Security # _____

1- Friend / Relative / Doctor: _____

Street Address _____

2- Insurance Provider List/Website

City, State, Zip _____

3- Walked By / Drove By

Email address _____

4- Eye to Eye Website

Occupation _____

5- YP ad / Newspaper / Mail / Radio / TV

Spouse's name _____ Children's names (ages) _____

Phone (H) _____ Phone (W) _____ Phone (Cell) _____

Medical Insurance Plan: _____

Vision Insurance Plan: _____

Policy ID#: _____

Policy ID#: _____

Group #: _____

Group #: _____

Employer _____

Employer _____

Insured's Name: _____ Insured's Birthdate _____

1- What is (are) the reason (s) for your visit today: _____

2- Please circle any problems that you have with your vision:

8- Current medications (Rx & non Rx) / Reason for taking:

- Worsening vision at: Far / Intermediate / Near
- Headaches / Dizziness / Double Vision / Eyestrain/
- Tired Eyes / Poor night vision /Haloes around lights/
- Floating Spots / Color Vision / Poor School Performance /
- Fluctuating Vision / Flashes of light / Other:

9- Allergies to medications:

3- Please circle any problems that you have with your eyes:

10- Indicate if you or anyone in your family has:

- Bloodshot / Itching / Burning / Watering / Grittiness/
- Puffy eyelids / Bumps / Lazy eye / Eye turn
- Mucous or pus discharge / Pain / Sensitive to light /

	<u>YOU</u>		<u>RELATIVE</u>	
	Yes	No	Yes	No (If yes, who?)

4- Please describe if/when you have ever had:

Eye disease/injury/surgery: _____

- | | | | | | |
|----------------------|--------------------------|--------------------------|--------------------------|--------------------------|-------|
| Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Asthma | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Cancer | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Cholesterol | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Heart problems | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| High blood pressure | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| HIV positive | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Macular degeneration | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Thyroid condition | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Other: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

5- Do you wear contact lenses now?

If not, are you interested in wearing them?

6- Are you interested in LASIK?

7- Are you interested in EYE RETAINERS (Ortho-K / CRT)?

How much do you do the following activities: (circle)

COMPUTER/MUSICAL INSTR/ READING (desk / lap / bed)

TV WATCHING

DRIVING

WALKING / RUNNING

GOLF / TENNIS

WATER / SNOW SPORTS

FOOTBALL/BASEBALL/SOCCER/VOLLEYBALL/HOOPS

Frequently Infrequently Never

Frequently Infrequently Never

Frequently Infrequently Never

Frequently Infrequently Never

Frequently Infrequently Never

Frequently Infrequently Never

Frequently Infrequently Never

Do you have eyewear specific for that activity?

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

THANK YOU FOR CHOOSING US!

Eye care has changed dramatically in the past 10 years, becoming dominated by the national optical chain stores. With their huge advertising budgets and emphasis on profits instead of quality care, they have created high volume vision factories that provide very basic care and offer a minimal variety of cheap quality eye care products. They advertise low prices and fast service, and this is quite appealing on the surface. As our lives have become more hectic, "fast food eye care" has become increasingly popular. Quality eye care in America is disappearing..

Not here. We are not a "fast-food" optical. We don't think that rushing through your "exam" in 5-10 minutes or making your glasses in one hour is something to be proud of. Our primary concern is providing our patients with superior quality eye care. We spend more time with you so that we can solve problems that you may not even know you have...because nobody ever took the time to test for them. Many people have now been conditioned to getting "quickie" eye care, and don't understand why we "don't do things the way their previous doctor did things" or "why they need such-and-such test".

We recognize that you have a choice in the selection of your eye care provider, and we will continually strive to ensure that your trust in us is justified. If there is anything we can do to make your visits to our office more pleasant or productive, please let us know. Additionally, it would be our pleasure to care for your family and friends to provide them the same personalized care that you receive. Please don't hesitate to refer our services to them, or have them give us a call if there are questions regarding their eye health. Thank you!

PAYMENT RESPONSIBILITY FOR SERVICES RENDERED

We are participating providers with many insurance companies, and we will be happy to file your insurance claim for you. Any deductibles or co-payments or surcharges not covered by your insurance company will be your responsibility. Please present your insurance card to us, so that we may copy it for your files.

I authorize payment to be made to Eye To Eye Vision Center for services rendered.

Patient or Authorized Person's Signature

TO OUR NEW PATIENTS WHO WEAR CONTACT LENSES OR ARE CONSIDERING CONTACT LENSES:

Contact lens evaluation requires us to perform additional tests beyond those normally done in a routine eye examination, so it is customary to charge an additional professional fee.

If the doctor decides that you would do better with a contact lens different from the brand you are currently wearing, or if there is a change in your prescription, there may be an additional charge for a contact lens fitting and/or follow-up visit(s). The degree of anticipated difficulty will determine the cost. Dr. Jeruss will discuss this with you after evaluating the condition of your eyes with your current contact lenses.

In the event that you discontinue the contact lens fitting process, you will still be responsible for a portion of the professional fitting fee. These fees are not covered by any vision insurance plans, and patients are responsible for payment.

Patient or Authorized Person's Signature