LENTZ EYE CARE PATIENT INFORMATION FORM

Please complete this form to the best of your knowledge.

Today's Date _____________

HOW DID YOU DECIDE TO COME TO OUR PRACTICE?

Referral (by whom) ____________________ Sign/Location ____________________

Newspaper _______ Yellow Pages _______ TV _______ Email _______ Website _______ Social Media _________

Employer ________ Insurance __________ Other ______________________________

Last Name: ______________________ **First Name:** ______________________ **MI:** ___

(circle: Mr., Mrs., Ms., Miss, Dr.) How do you wish to be address?

Address: ____

Street Address / PO Box # City State Zip

Patient Home Phone: (   ) ______________________ **Patient Age:** ______________________ ☐M ☐F

Patient Cell Phone: (   ) ______________________ **Patient Date of Birth** ______________________

Patient Email Address: ____

***We abide by all HIPPA privacy regulations and do not sell or market your demographic information, including your e-mail address, to anyone.**

Patient Employer: ______________________ **Employer Phone: (   )** ______________________

Name of Spouse: ______________________ **Spouse Employer:** ______________________

Patient SS#: ______________________ **Person Responsible for Payment:** ______________________

IF PATIENT IS A CHILD:

Father's Name: ______________________ **Mother's Name:** ______________________

Father's SS#: ______________________ **Mother's SS#:** ______________________

Father's Cell Phone: (   ) ______________________ **Mother's Cell Phone: (   )** ______________________

Father's Employer: ______________________ **Mother's Employer:** ______________________

Name of Medical Doctor: ______________________ **Date of Last Eye Exam:** ______________________

Medical Doctor Phone: (   ) ______________________ **Last Eye Dr Seen:** ______________________

Date of Last Medical Exam: ______________________ **Reason for leaving previous office:** ______________________

INSURANCE INFORMATION

Insurance Company: ______________________ **Policyholder's Name:** ______________________

Policyholder's ID#: ______________________ **Group #:** ______________________

Policyholder's DOB: ______________________ **Policyholder's SS#:** ______________________

I would like to discuss/learn more about: **Glasses** **Sunglasses** **Contact Lenses** **Laser Refractive Surgery**

Hobbies: ____

Financial Assignment Information:

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will immediately due and payable to Lentz Eye Care.

Initial _______ Date: _____________

MEDICAL HISTORY

Do you have any allergies to medications? ❑ No ❑ Yes If yes, please explain: ______

List any medications **you** take *(including all oral medications, eye medications and eye drops, oral contraceptives, aspirin, over the counter medications and home remedies):*

______

List all major injuries, surgeries and/or hospitalizations **you** have had: ______

List any of the following that **you** have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye injury: ______

Are your pregnant and/or nursing? ❑ No ❑ Yes
Do you wear glasses? ❑ No ❑ Yes If yes, how old is your present pair of lenses?
Do you wear contact lenses? ❑ No ❑ Yes If yes, how old is your present pair of contacts?
Type of contact lenses: ❑ Rigid ❑ Soft ❑ Disposable ❑ Other Are they comfortable? ❑ Yes ❑ No

FAMILY HISTORY

Please note any personal or family history (parents, grandparents, siblings, children, living or deceased) for the following conditions.

DISEASE/CONDITION	Self	Family	WHOM	DISEASE/CONDITION	Self	Family	WHOM
Blindness	❑	❑	______	Diabetes	❑	❑	______
Cataract	❑	❑	______	Heart Disease	❑	❑	______
Crossed Eyes	❑	❑	______	High Blood Pressure	❑	❑	______
Glaucoma	❑	❑	______	Kidney Disease	❑	❑	______
Macular Degeneration	❑	❑	______	Lupus	❑	❑	______
Retinal Detachment/Disease	❑	❑	______	Thyroid Disease	❑	❑	______
Arthritis	❑	❑	______	Multiple Sclerosis	❑	❑	______
Cancer	❑	❑	______	Other	❑	❑	______

SOCIAL HISTORY

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

❑ Yes, I would prefer to discuss my Social History information directly with my doctor. (Check box)

Do you drive? ❑ No ❑ Yes If yes, do you have visual difficulty when driving? ❑ No ❑ Yes If yes, please describe:

Do you use tobacco products? ❑ No ❑ Yes If yes, type/amount/how long: ______
Do you drink alcohol? ❑ No ❑ Yes If yes, type/amount/how long: ______
Do you use illegal drugs? ❑ No ❑ Yes If yes, type/amount/how long: ______
Have you ever been exposed to or infected with ❑ Gonorrhea ❑ Hepatitis ❑ HIV ❑ Syphilis

REVIEW OF SYSTEMS

Do you currently, or have you ever had any problems in the following areas:

SYSTEM	NO	YES	?
CONSTITUTIONAL			
Fever, Weight Loss / Gain	❑	❑	❑
INTEGUMENTARY (Skin)	❑	❑	❑
NEUROLOGICAL			
Headaches	❑	❑	❑
Migraines	❑	❑	❑
Seizures	❑	❑	❑
EYES			
Loss of Vision	❑	❑	❑
Blurred Vision	❑	❑	❑
Distorted Vision / Halos	❑	❑	❑
Loss of Side Vision	❑	❑	❑
Double Vision	❑	❑	❑
Dryness	❑	❑	❑
Mucous Discharge	❑	❑	❑
Redness	❑	❑	❑
Sandy or Gritty Feeling	❑	❑	❑
Itching	❑	❑	❑
Burning	❑	❑	❑
Foreign Body Sensation	❑	❑	❑
Excess Tearing / Watering	❑	❑	❑
Glare / Light Sensitivity	❑	❑	❑
Eye Pain or Soreness	❑	❑	❑
Chronic Infection of Eye or Lid	❑	❑	❑
Sties or Chalazion	❑	❑	❑
Flashes / Floaters in Vision	❑	❑	❑
Tired Eyes	❑	❑	❑
ENDOCRINE			
Thyroid / Other Glands	❑	❑	❑
EARS, NOSE, MOUTH, THROAT			
Allergies / Hay Fever	❑	❑	❑
Sinus Congestion	❑	❑	❑
Runny Nose	❑	❑	❑
Post-Nasal Drip	❑	❑	❑
Chronic Cough	❑	❑	❑
Dry Throat / Mouth	❑	❑	❑
RESPIRATORY			
Asthma	❑	❑	❑
Chronic Bronchitis	❑	❑	❑
Emphysema	❑	❑	❑
VASCULAR / CARDIOVASCULAR			
Diabetes	❑	❑	❑
Heart Pain	❑	❑	❑
High Blood Pressure	❑	❑	❑
Vascular Disease	❑	❑	❑
GASTROINTESTINAL			
Constipation	❑	❑	❑
Diarrhea	❑	❑	❑
GENITOURINARY			
Genitals / Kidney / Bladder	❑	❑	❑
BONES / JOINT / MUSCLES			
Rheumatoid Arthritis	❑	❑	❑
Muscle Pain	❑	❑	❑
Joint Pain	❑	❑	❑
LYMPHATIC / HEMATOLOGIC			
Anemia	❑	❑	❑
Bleeding Problems	❑	❑	❑
ALLERGIC / IMMUNOLOGIC	❑	❑	❑
PSYCHIATRIC	❑	❑	❑

If you answered YES to any of the above or have a condition not listed, please explain & list medications: ______

Dr's Sig. ______ Date ______ Patient's Sig. ______ Date ______

Dr's Sig. ______ Date ______ Patient's Sig. ______ Date ______

Dr's Sig. ______ Date ______ Patient's Sig. ______ Date ______