

# Art of Optiks

## Welcome Back To Our Office

Welcome to Art of Optiks. Thank you for choosing us for your eyecare needs. We're delighted to have you as a patient and appreciate the confidence you placed in us. Please take a moment to complete the following information. Any data already on file will appear on this form. To better care for you, please review all completed areas to ensure accuracy.

Mr.  Miss  Mrs.  Ms.

Male  Female

\_\_\_\_\_  
First Name

\_\_\_\_\_  
MI

\_\_\_\_\_  
Last Name

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State Zip

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Home Phone - Include Area Code

\_\_\_\_\_  
Work Phone

\_\_\_\_\_  
Email Address

\_\_\_\_\_  
Spouse or Parent(s) Name

\_\_\_\_\_  
Person Responsible for Account (Must sign at bottom)

\_\_\_\_\_  
School Name

Mr.  Ms.

\_\_\_\_\_  
Teacher's Name

\_\_\_\_\_  
Grade

What is the main reason for today's exam ? \_\_\_\_\_ When was your last exam ? \_\_\_\_\_

How were you referred to our office?

Phone Book  School  Advertisement  Patient (Please Name) \_\_\_\_\_

Insurance Listing  Drive by  Other \_\_\_\_\_  Doctor (Please Name) \_\_\_\_\_

### **Primary Insurance Information**

\_\_\_\_\_  
Name and Address of Primary Insurance Company

\_\_\_\_\_  
City

\_\_\_\_\_  
State Zip

M  F

\_\_\_\_\_  
Insured's (ie. employee/cardholder) First Name

\_\_\_\_\_  
MI

\_\_\_\_\_  
Insured's (ie. employee/cardholder) Last Name

\_\_\_\_\_  
Patient's Identification Number

\_\_\_\_\_  
Group Number

\_\_\_\_\_  
Insured's (ie. cardholder/employee) Date of Birth

#### **Patient Relationship to Insured**

Self  Spouse  Child  Other

#### **Patient Status**

Single  Married  Other

Full Time Student  Part Time Student  Employed

### **Secondary Insurance Information**

\_\_\_\_\_  
Name and Address of Primary Insurance Company

\_\_\_\_\_  
City

\_\_\_\_\_  
State Zip

M  F

\_\_\_\_\_  
Insured's First Name

\_\_\_\_\_  
MI

\_\_\_\_\_  
Insured's Last Name

#### **Patient Relationship to Insured**

\_\_\_\_\_  
Patient's Identification Number

\_\_\_\_\_  
Group Number

\_\_\_\_\_  
Insured's Date of Birth

Self  Spouse  Child  Other

### **Please Read:**

We require that all fees for professional services and materials be paid at which time the services and/or materials are rendered/ordered. We would rather control billing costs than be forced to raise our fees. The undersigned agrees that they are ultimately responsible for all bills incurred in this office regardless of insurance. Copayments are due on day of service. There will be a \$25.00 billing fee for any copays not paid on service date. Accounts 90 days old are subject to late fees, interest charges, and if necessary, any subsequent collection or attorney fees. There will be a \$31.00 service fee on all returned checks. Any fees paid by my insurance company will be paid directly to Art of Optiks. I accept that will be billed as my primary insurance. I realize that not supplying correct info may result in my owing the entire balance. I agree that billing any secondary insurance company will be my responsibility. I understand that there are no guarantees of payment with any insurance billing and my final balance can only be determined after the claim is processed. I agree to all of the aforementioned.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

PATIENT HISTORY AND INFORMATION

VISUAL HISTORY

Current Occupation : \_\_\_\_\_ Years \_\_\_\_\_ Employer \_\_\_\_\_

Do you use a computer ?  Yes  No How many hours/day \_\_\_\_\_ Distance from Computer \_\_\_\_\_

Do you drive?  Yes  No Mileage to work each way \_\_\_\_\_ Do you have glare problems?  Yes  No

Do you have visual difficulty when driving?  Yes  No

Do you have problems with night vision?  Yes  No

SPECTACLE LENS HISTORY

Do you currently wear glasses ?  Yes  No Since \_\_\_\_\_

Type of glasses  Full Time  Part Time  Distance  Close

Glasses Owned

Single Vision  Bifocals  Trifocals  Back-up Glasses  Safety Glasses  Sports Glasses  Progressive

Have you had trouble in the past with glasses?  Yes  No \_\_\_\_\_

Do you wear sunglasses ?  Yes  No Are your sun glasses your current prescription ?  Yes  No

CONTACT LENS HISTORY

Have you ever tried to wear contact lenses ?  Yes  No Reason for stopping \_\_\_\_\_

Do you currently wear contact lenses ?  Yes  No Since \_\_\_\_\_

If not a contact lens wearer, are you interested in trying contact lenses at this time ?  Yes  No

Type and brand of contact lenses \_\_\_\_\_ Today's wearing time ? \_\_\_\_\_

How many hours/day ? \_\_\_\_\_ How many days/week ? \_\_\_\_\_

Please rate the following on a scale of 1-10, with 1 being POOR to 10 being EXCELLENT

Right Left Right Left Right Left

Lens Comfort : \_\_\_\_\_ Distance Vision : \_\_\_\_\_ Near Vision : \_\_\_\_\_

What Solutions do you use? Cleaner \_\_\_\_\_ Disinfectant \_\_\_\_\_ Enzyme \_\_\_\_\_

SOCIAL HISTORY

Do you use nutritional supplements (vitamins etc.)?  Yes  No

Do you engage in regular exercise?  Yes  No

Do you drink alcohol ? If yes, how much/often :  No  Occasional  1 per day  2-3/day  4+/day

Do you smoke ? If yes, how much/often :  No  Occasional  1/2 pack/day  1 pack/day  1+ pack

Hobbies/ Interests : \_\_\_\_\_

SPECIAL EYEWEAR NEEDS

- Computer (special prescriptions, special anti-glare tints or coatings)  Safety Glasses (gardening, woodworking, welding)
 Occupational (mechanics, plumbers, pilots)  Sports/Hobbies (racquet sports, motorcycle)

# MEDICAL HISTORY QUESTIONNAIRE

## EYE HISTORY

Headaches	<input type="radio"/> Yes <input type="radio"/> No	Foreign Body Sensation	<input type="radio"/> Yes <input type="radio"/> No	Blurred Vision Distance	<input type="radio"/> Yes <input type="radio"/> No
Glare/Light Sensitivity	<input type="radio"/> Yes <input type="radio"/> No	Infection of Eye or Lid	<input type="radio"/> Yes <input type="radio"/> No	Blurred Vision Near	<input type="radio"/> Yes <input type="radio"/> No
Tired Eyes	<input type="radio"/> Yes <input type="radio"/> No	Itching	<input type="radio"/> Yes <input type="radio"/> No	Distorted Vision (halos)	<input type="radio"/> Yes <input type="radio"/> No
Amblyopia (Lazy Eye)	<input type="radio"/> Yes <input type="radio"/> No	Mucous Discharge	<input type="radio"/> Yes <input type="radio"/> No	Double Vision	<input type="radio"/> Yes <input type="radio"/> No
Burning	<input type="radio"/> Yes <input type="radio"/> No	Drooping Eyelid	<input type="radio"/> Yes <input type="radio"/> No	Floaters or Spots	<input type="radio"/> Yes <input type="radio"/> No
Dryness	<input type="radio"/> Yes <input type="radio"/> No	Redness	<input type="radio"/> Yes <input type="radio"/> No	Fluctuating Vision	<input type="radio"/> Yes <input type="radio"/> No
Excess Tearing/Watering	<input type="radio"/> Yes <input type="radio"/> No	Sandy or Gritty Feeling	<input type="radio"/> Yes <input type="radio"/> No	Loss of Vision	<input type="radio"/> Yes <input type="radio"/> No
Eye Pain or Soreness	<input type="radio"/> Yes <input type="radio"/> No	Strabismus (Crossed Eyes)	<input type="radio"/> Yes <input type="radio"/> No	Loss of Side Vision	<input type="radio"/> Yes <input type="radio"/> No
Eye Twitching	<input type="radio"/> Yes <input type="radio"/> No	Other _____			

## GENERAL HEALTH CONDITION

Fever	<input type="radio"/> Yes <input type="radio"/> No	Kidney	<input type="radio"/> Yes <input type="radio"/> No
Weight Loss	<input type="radio"/> Yes <input type="radio"/> No	Muscles, Bones, Joints	<input type="radio"/> Yes <input type="radio"/> No
Other Symptoms	<input type="radio"/> Yes <input type="radio"/> No	Skin	<input type="radio"/> Yes <input type="radio"/> No
Ears, Nose, Throat	<input type="radio"/> Yes <input type="radio"/> No	Neurological (MS)	<input type="radio"/> Yes <input type="radio"/> No
High Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Psychiatric (Anxiety, Depression, Insomnia)	<input type="radio"/> Yes <input type="radio"/> No
Respiratory (Asthma)	<input type="radio"/> Yes <input type="radio"/> No	Diabetes, thyroid	<input type="radio"/> Yes <input type="radio"/> No
Gastrointestinal	<input type="radio"/> Yes <input type="radio"/> No	Blood/Lymph (cholesterol)	<input type="radio"/> Yes <input type="radio"/> No
		Allergic/Immunologic	<input type="radio"/> Yes <input type="radio"/> No

Past Illnesses or Injuries: \_\_\_\_\_

Past Surgeries: \_\_\_\_\_

Current Medications: \_\_\_\_\_

Medicines that cause reactions or sensitivities: \_\_\_\_\_

Specific Allergies: \_\_\_\_\_

## FAMILY HISTORY

Lazy Eye	<input type="radio"/> Yes <input type="radio"/> No	Arthritis	<input type="radio"/> Yes <input type="radio"/> No
Blindness	<input type="radio"/> Yes <input type="radio"/> No	Cancer	<input type="radio"/> Yes <input type="radio"/> No
Cataract(s)	<input type="radio"/> Yes <input type="radio"/> No	Diabetes	<input type="radio"/> Yes <input type="radio"/> No
Color Blindness	<input type="radio"/> Yes <input type="radio"/> No	Heart Disease	<input type="radio"/> Yes <input type="radio"/> No
Glaucoma	<input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No
Macular Degeneration	<input type="radio"/> Yes <input type="radio"/> No	Kidney Disease	<input type="radio"/> Yes <input type="radio"/> No
Retinal Detachment	<input type="radio"/> Yes <input type="radio"/> No	Lupus	<input type="radio"/> Yes <input type="radio"/> No
Eye Turn	<input type="radio"/> Yes <input type="radio"/> No	Stroke	<input type="radio"/> Yes <input type="radio"/> No
		Thyroid Disease	<input type="radio"/> Yes <input type="radio"/> No