

Welcome to . Thank you for choosing us for your eyecare needs. We are 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 information we already have on file will appear on this form. Please review all completed areas to ensure that the information we have is current and accurate. If you have any questions, please do not hesitate to ask.

Mr.  Miss  Mrs.  Ms.

Male  Female

\_\_\_\_\_  
 First Name MI Last Name Preferred Name

\_\_\_\_\_  
 Street Address City State Zip

\_\_\_\_\_  
 Social Security Number Date of Birth Home Phone - Include Area Code Day Phone

\_\_\_\_\_  
 Email Address Guardian Person Responsible for Account

\_\_\_\_\_  
 Emergency Contact Emergency Phone

How were you referred to our office?

Who were you referred by?

- Phone Book  School  Advertisement  Patient  
 Insurance Listing  Drive by  Other  Doctor

**PRIMARY INSURANCE INFORMATION**

\_\_\_\_\_  
 Name and Address of Primary Insurance Company City State Zip

M  F

\_\_\_\_\_  
 Insured's First Name MI Insured's Last Name

\_\_\_\_\_  
 Insured's Identification Number Group Number Insured's Date of Birth

**Patient Relationship to Insured**

**Patient Status**

- Self  Spouse  Child  Other

- Single  Married  Other  
 Full Time Student  Part Time Student  Employed

**SECONDARY INSURANCE INFORMATION**

\_\_\_\_\_  
 Name and Address of Secondary Insurance Company City State Zip

M  F

\_\_\_\_\_  
 Insured's First Name MI Insured's Last Name

\_\_\_\_\_  
 Insured's Identification Number Group Number Insured's Date of Birth

**Patient Relationship to Insured**

- Self  Spouse  Child  Other

**Please Read:**

In order to control the cost of billing, we ask that the patient's portion is paid at the time services are rendered unless other arrangements are made in advance. We would rather control billing costs than be forced to raise our fees. All professional services and material are charged to the patient. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Accounts 90 days old are subject to collection fees. There will be a service charge on all returned checks.

Payment from my insurance is to be paid directly to . I understand that will be billed as my primary insurance. I understand that billing any secondary insurance is my responsibility. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed.

\_\_\_\_\_  
 Signature

\_\_\_\_\_  
 Date

Name \_\_\_\_\_

### PATIENT HISTORY AND INFORMATION

Race

<input type="checkbox"/> American Indian Or Alaska Native	<input type="checkbox"/> Other Race	<input type="checkbox"/> Refuse To Specify
<input type="checkbox"/> Asian	<input type="checkbox"/> White	<input type="checkbox"/> Not Disclosed
<input type="checkbox"/> Black Or African American	<input type="checkbox"/> Native American	
<input type="checkbox"/> Native Hawaiian Or Other Pacific Islander	<input type="checkbox"/> Caucasian	

Other Race

Ethnicity

Hispanic Or Latino    Not Hispanic Or Latino    Unknown

Preferred Language

English    Spanish    French    Italian    Russian    Portuguese

Height	<input type="text"/>	ft	<input type="text"/>	in	<input type="text"/>	cm/m	<input type="radio"/> ft in	<input type="radio"/> cm	<input type="radio"/> m	Weight	<input type="text"/>	<input type="radio"/> lbs	<input type="radio"/> kg
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#### PRIMARY CARE PHYSICIAN

Primary Care Physician and Clinic Name \_\_\_\_\_

Address of Primary Care Physician      City      State      Zip      Phone

#### REFERRING PHYSICIAN

Referring Physician and Clinic Name \_\_\_\_\_

Address of Referring Physician      City      State      Zip      Phone

#### HEALTH HISTORY

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

When was your last health exam ? \_\_\_\_\_

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

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

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

Current Eye Drops: \_\_\_\_\_

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

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

#### EYE HISTORY

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

**GENERAL HEALTH CONDITION**

Fever  Yes  No  
 Weight Loss  Yes  No  
 Other Symptoms  Yes  No  
 Ears, Nose, Throat  Yes  No  
 Cardiovascular (high blood pressure etc.)  Yes  No

Respiratory (Asthma)  Yes  No  
 Gastrointestinal  Yes  No  
 Kidney  Yes  No  
 Muscles, Bones, Joints  Yes  No  
 Skin  Yes  No  
 Neurological (Multiple Sclerosis)  Yes  No

Anxiety or Depression  Yes  No  
 Thyroid, Diabetes  Yes  No  
 Blood/Lymph  Yes  No  
 Allergic  Yes  No  
 Are you?  Pregnant  Nursing

Name \_\_\_\_\_

**MEDICAL HISTORY QUESTIONNAIRE****FAMILY HISTORY**

Amblyopia (Lazy Eye)  Yes  No  
 Blindness  Yes  No  
 Cataract(s)  Yes  No  
 Color Blindness  Yes  No  
 Glaucoma  Yes  No  
 Macular Degeneration  Yes  No

Retinal Detachment  Yes  No  
 Strabismus (Eye Turn)  Yes  No  
 Arthritis  Yes  No  
 Cancer  Yes  No  
 Diabetes  Yes  No  
 Heart Disease  Yes  No

High Blood Pressure  Yes  No  
 Kidney Disease  Yes  No  
 Lupus  Yes  No  
 Stroke  Yes  No  
 Thyroid Disease  Yes  No  
 Others  Yes  No

**SOCIAL HISTORY**

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

**SPECTACLE LENS HISTORY**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  NoDo you have visual difficulty when driving?  Yes  NoDo you have problems with night vision?  Yes  NoDo you currently wear glasses ?  Yes  No Since \_\_\_\_\_Type of glasses  FullTime  PartTime  Distance  CloseGlasses Owned  SingleVision  Bifocals  Trifocals  Backup  Safety  Sports  ProgressiveHave 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**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)**CONTACT LENS HISTORY**If not a contact lens wearer, are you interested in trying contact lenses at this time ?  Yes  NoHave you ever tried to wear contact lenses?  Yes  No Reason for stopping? \_\_\_\_\_Do you currently wear contact lenses?  Yes  No Since \_\_\_\_\_

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 \_\_\_\_\_

Name

**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

Smoking Status

Method of Tobacco Intake :  Smoking  Chewing

Do you use Illegal Drugs :  Yes  No

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

# OPHTHALMIC CONSULTANTS OF CHICAGO

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## Consent for Release of Confidential Information

Ophthalmic Consultants of Chicago respects the privacy of every patient and does its best to protect such information. We will however release medical information to another physician when it is necessary for the treatment of our patients. Please know that only pertinent information will be released to ensure that your privacy is maintained.

There are also times when your insurance carrier requires additional health information in order to process payment for claims. In these instances, only the relevant information will be provided to them. Again, we do our best to protect your health information.

I understand that the Ophthalmic Consultants of Chicago has the right to release my health information for the above reasons. I also know that they will protect my information to the best of their ability.

This consent is valid the entire length of my relationship with the Ophthalmic Consultants of Chicago. Should I feel it is necessary to revoke this notice, I understand it must be done in writing to my physician's office.

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Patient's Name or Consenting Party

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Date

More detailed information is available from our front desk staff upon request.