## MEDICAL HISTORY

Do you use a computer screen? ☐ No ☐ Yes; how much? ______

Do you smoke? ☐ No ☐ Yes    Do you use prescription sunglasses? ☐ No ☐ Yes

Name of family physician (first & last) and city ______

Name of last eye doctor (first & last) and city ______

When was your last eye exam? ______

List medications you are taking (include hormones, birth control, eye drops and non-prescription medications) ☐ None

______

List any medication allergies ☐ None ______

Check any medical conditions that apply to you ☐ None

| | | | | |
|---|---|---|---|---|
| ☐ Diabetes | ☐ Allergies | ☐ Asthma | ☐ Heart Disease | ☐ High Cholesterol |
| ☐ Headaches | ☐ Cancer | ☐ Arthritis | ☐ Lung Disease | ☐ High Blood Pressure |
| ☐ Seizures | ☐ Head Trauma | ☐ Other ______ | | |

Please list any surgeries you have had done and when ☐ None

______

______

Do you use cigarettes/tobacco? ______ Alcohol? ______ Other Substances ______

Check any eye conditions that apply to you ☐ None

| | | | | |
|---|---|---|---|---|
| ☐ Cataracts | ☐ Glaucoma | ☐ Lazy Eye | ☐ Eye Surgery | ☐ Refractive Surgery |
| ☐ Glasses | ☐ Contacts | ☐ Infection | ☐ Eye Disease | ☐ Vision Therapy |
| ☐ Other ______ | | | | |

Check conditions that are present in other family members ☐ None

☐ Cataracts ☐ Glaucoma ☐ Lazy Eye ☐ Diabetes ☐ Heart Disease ☐ High Blood Pressure

☐ Other Eye Disease ______

☐ Other Inherited Conditions ______

## CONTACT LENS HISTORY

☐ Not interested in contact lenses

☐ Would like to know my contact lens options

☐ Problems with contacts ______

______

☐ Allergic to lens care solutions ______

______

☐ Lens care system ______

**TYPE OF CONTACT LENSES**

☐ Soft disposables ☐ 1 day ☐ 1 month ☐ 2 week ☐ 3 month

☐ Soft contact lenses

☐ Astigmatism soft contacts lenses

☐ Gas permeable

☐ Bifocal Lenses ☐ soft ☐ hard

☐ Other ______

*Today's Date* ______

# PAYE EYE CARE CENTER
# PATIENT INFORMATION

*(Please Print)*

Patient Name (Last) ____________________ (First) _________________ (Middle Int.) ________ (Circle one) Mr. Mrs. Miss Ms.

Address ______________________________ (City) ______________________ (State) _______________ (Zip) _______________

Home Phone ( ) ______________________ Business Phone ( ) ________________________ Ext. ____________________

I prefer to be addresses as __________________________________ Parent or Spouse's Name _______________________________

Date of Birth ____________________ Age _____________ *(circle one)*

Social Security # ______________________________________ Medicare # _______________________________________________

Employer ____________________________________________ Occupation ______________________________________________

Student / Grade _____________________

Method of payment: ___ Cash ____ Check ___ Credit Card ___ Medicare ___ Insurance

How did you hear about our office? __ Phone Book __ Internet __ Newspaper __ Mailing __ Insurance __ Patient __________________

## BILLING INFORMATION
## *(If different from above)*

Person responsible (Last) _____________________ (First) _____________ (Middle Int.) ______ (Circle One) Mr. Mrs. Miss Ms.

Address ______________________________ (City) ______________________ (State) _______________ (Zip) _______________

Home Phone ( ) ______________________ Business Phone ( ) ________________________ Ext. ____________________

Employer ____________________________________________ Occupation ______________________________________________

Relationship to Patient ___________________________________________________________________________________________

## FAMILY MEMBERS RESIDING WITH YOU *(circle correct category and fill in name)*

Name ____________________________________________________ (circle one) Husband / Father

Name ____________________________________________________ (circle one) Husband / Father

Name ____________________________________________________ Age _____ (circle one) Daughter / Son / Sister / Brother

Name ____________________________________________________ Age _____ (circle one) Daughter / Son / Sister / Brother

Name ____________________________________________________ Age _____ (circle one) Daughter / Son / Sister / Brother

Name ____________________________________________________ Age _____ (circle one) Daughter / Son / Sister / Brother

Name ____________________________________________________ Age _____ (circle one) Daughter / Son / Sister / Brother

Name ____________________________________________________ Age _____ (circle one) Daughter / Son / Sister / Brother

Name ____________________________________________________ Age _____ (circle one) Daughter / Son / Sister / Brother

## TERMS AND CONDITIONS

AUTHORIZATION TO RELEASE INFORMATION AND TO PAY BENEFITS TO PAYE / EYECARE CENTER. I hereby authorize Paye / EyeCare Center to release information acquired in the course of my examination to my insurance company. I understand that my health care insurance carrier or payer of my benefits may pay less than the actual bill for services. I understand that I am financially responsible for payment in full of all amounts not covered by insurance or other third party payers.

***AMOUNTS DUE PAST 45 DAYS ARE SUBJECT TO 1 - 1/2% PER MONTH LATE FEE (18% PER YEAR)***

_______________________________________________ _______________________________

Signature (Parent / Guardian, if patient is a minor) Date