**Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_First\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ M.I.\_\_\_\_ Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Nickname:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Gender: M F ) Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_ \_\_ Cell Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN\_\_\_\_\_\_\_-\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Parent/Guardian (if applicable)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-Mail:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Primary Care physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Eye Exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Referred by:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**HIPAA Notice and Acknowledgement**

I acknowledge that I have been provided the HIPAA Notice of Privacy Practices \_\_\_Yes \_\_\_\_No

**Chief Complaint:** What is your primary reason for this visit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you experiencing any of the following ocular or visual symptoms? (Check all that apply)

Blurred Vision \_\_\_\_ Light Sensitivity \_\_\_\_ Reduced Night Vision \_\_\_\_

Burning Eyes \_\_\_\_ Itchy, Watery Eyes \_\_\_\_ Reduced Side Vision \_\_\_\_

Excessive Tearing \_\_\_\_ Dry, Gritty Feeling \_\_\_\_ Halos around Lights \_\_\_\_

Noticeable Redness \_\_\_\_ Pain or Discomfort \_\_\_\_ Flashes or Flickers \_\_\_\_

Double Vision \_\_\_\_ New Floaters/Spots \_\_\_\_ Loss of Vision \_\_\_\_

Have you ever been diagnosed with, or treated for, any of the following ocular conditions?

Retinal Detachment \_\_\_\_ Ocular Infections \_\_\_\_ Lazy or Turned Eye \_\_\_\_

Cataracts \_\_\_\_ Glaucoma \_\_\_\_ Styes, Inflamed Lids \_\_\_\_

Macular Degen. \_\_\_\_ Disease of Retina \_\_\_\_

Do you now wear glasses? \_\_\_\_\_\_\_\_ If so, how old are they? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How is your vision with them? \_\_\_\_\_\_\_\_\_\_\_\_\_ Are they comfortable? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What type? \_\_\_\_ Readers \_\_\_\_Distance \_\_\_\_ Bifocal \_\_\_\_ Trifocal \_\_\_\_Progressive

**ATTENTION CONTACT LENS PATIENTS:**

**A contact lens fitting is a professional service separate from the routine vision exam***.* The fitting includes the trial lenses and any follow-up appointments to provide you with a contact lens prescription. By signing below, you acknowledge that you can use your insurance benefits to cover the contact lens fitting, **OR** you will pay for the contact lens fitting at the time of service.

Signature (patient/ responsible party)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you currently wear contact lenses?\_\_\_\_\_\_\_\_ What type/brand?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hours per day?\_\_\_\_\_\_\_\_\_\_\_\_

Do you use a computer?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How many hours per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any previous surgeries or injuries to your eyes?\_\_\_\_\_\_\_\_\_ If so, please describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Using any ocular medicines? \_\_\_\_\_\_\_\_ Please list if known: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What hobbies, activities, and/or sports do you enjoy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Would you be willing to provide feedback to us on your experience today via a text message or e-mail survey?** \_\_\_\_Yes \_\_\_\_No

**Medical History:**

Do you have any allergies to medicines?\_\_\_\_\_\_\_\_\_ If so, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you taking any Rx or OTC medicines?\_\_\_\_\_\_\_\_\_ If so, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any previous injuries, surgeries, or hospitalizations? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you pregnant or nursing? \_\_\_\_\_\_\_\_\_\_ If pregnant, list due date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been diagnosed with or treated for any of the following problems? (Check all that apply)

**Allergy**  Food \_\_\_\_ Seasonal\_\_\_\_ **Genitourinary Musculoskeletal**

**Cardiovascular** Bladder Infection \_\_\_\_ Arthritis \_\_\_\_

Heart Problems \_\_\_\_ Kidney Stones \_\_\_\_ Joint Pain \_\_\_\_

High Blood Pressure \_\_\_\_ **Cranial/Facial** Muscle Pain \_\_\_\_

**Constitutional** Chronic Cough \_\_\_\_ **Neurological**

Fever \_\_\_\_ Dry Mouth \_\_\_\_ Headaches \_\_\_\_

Weight Gain \_\_\_\_ Sinus Infection \_\_\_\_ Migraines \_\_\_\_

Weight Loss \_\_\_\_ Ear Infection \_\_\_\_ Seizures \_\_\_\_

Dizziness/Fainting \_\_\_\_ Hearing Loss \_\_\_\_ Bell’s Palsy \_\_\_\_

**Endocrine Hematologic/Lymphatic** CP/MS/MD/MG \_\_\_\_

Diabetes \_\_\_\_ Anemia \_\_\_\_ **Psychiatric**

Thyroid Disorder \_\_\_\_ Clotting/Bleeding Depression \_\_\_\_

Elevated Cholesterol \_\_\_\_ Disorders \_\_\_\_ ADD/ADHD \_\_\_\_

**Gastrointestinal Immunologic** Alzheimers/Dementia\_\_\_

Gastrointestinal Disorder \_\_\_\_ HIV/AIDS \_\_\_\_ **Respiratory**

Hepatitis \_\_\_\_ Syphilis \_\_\_\_ Asthma \_\_\_\_

Gall Bladder \_\_\_\_ Lupus \_\_\_\_ Chronic Bronchitis \_\_\_\_

Ulcers \_\_\_\_ Mononucleosis \_\_\_\_ Emphysema, COPD \_\_\_\_

Shingles \_\_\_\_ Tuberculosis \_\_\_\_

**Social History:**

Do you drive? \_\_\_\_yes \_\_\_\_No If yes, are you having any visual difficulties? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use tobacco products? \_\_\_\_Yes \_\_\_\_No If so, how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use alcohol? \_\_\_\_Yes \_\_\_\_No If so, how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a history of drug or alcohol abuse? \_\_\_\_Yes \_\_\_\_No If yes, how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been exposed to HIV or other sexually transmitted diseases? \_\_\_\_Yes \_\_\_\_No

**Family Medical History:**

In your immediate family, is there any history of the following conditions?

Blindness: Injury\_\_\_ Disease\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Turned or Lazy Eyes \_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cataracts \_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Glaucoma \_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Macular Degeneration \_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Retinal Detach/Disease \_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Arthritis \_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cancer \_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diabetes \_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Heart Disease \_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

High Blood Pressure \_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Kidney Disease \_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Lupus \_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Thyroid Disease \_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Insurance Information**

**Vision Plan or Medical Insurance being billed today:**

Primary’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Primary’s DOB: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_

Name of Plan or Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Primary’s Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Member ID or SSN Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Consent to Treatment**

The doctor at Active Eyecare of Surprise is licensed to provide both routine vision exams and medical eye exams. If you are here today for a routine vision exam and your complaint or initial assessment indicates that there is a significant medical condition that requires treatment, you will be either provided with appropriate treatment today; referred to the appropriate specialist for treatment; or rescheduled for a medical examination. Active Eyecare is not a contracted provider for medical visits so the charges for your visit will be payable at the time of service. The doctor will discuss any such condition with you prior to initiating medical treatment, and it is your responsibility to consent to treatment or request referral to the appropriate specialist.

**Acknowledgements and Signature**

I acknowledge that the health and insurance information I have provided above is true and correct to the best of my ability. I authorize payment of any vision or medical benefits I may be eligible for directly to Active Eyecare of Surprise. **I agree that if my employer, insurance carrier, or plan sponsor denies payment to all or any part of my claim, I will be financially responsible for all outstanding charges.** I acknowledge that authorization obtained at the time of service does not guarantee payment, and any services not covered by insurance will be billed to me. In the event it becomes necessary to place any unpaid balances I am responsible for in collection, I agree to pay any collection fees, reasonable attorney fees, filing fees, and other costs the court determines are proper. I have read the conditions of service, and as the Patient or the Patient’s Authorized Representative I hereby accept these terms.

**Signature of Patient or \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Responsible Party**