BEACON ADVANCED EYECARE CENTER

WELCOME TO OUR OFFICE

Date _____

Last _____ First _____ MI ____
Date of Birth _____ Age _____ Sex M F
Address _____
City _____ State _____ Zip _____
Home Phone _____ Work Phone _____
Cell Phone _____ SS# _____
Email Address _____
Employer or School _____
Occupation / Grade _____
Spouse or Parent's Name _____
Spouse or Parent's Date of Birth _____
What is the major purpose of this visit? _____
_____
Any problems with your present contact lenses or glasses?
_____
_____

VERY IMPORTANT! NEW PATIENTS ONLY:
Who may we thank for referring you to our office?
Name of friend or relative _____
If not referred, how did you choose our office for your needs?

☐ Another Dr ☐ Insurance List
☐ Saw Sign/Building ☐ Newspaper/Radio/TV
☐Yellow Pages: Which Directory? _____
☐ Web Page : Which Web Site? _____
Other _____

INSURANCE INFORMATION

Vision Insurance _____
Subscriber Name _____
Subscriber SS# _____ Birth Date _____

Provider Medical Insurance _____
Subscriber Name _____
Subscriber SS# _____ Birth Date _____
Spouse's Name _____
Spouse's Birth Date _____

FAMILY MEDICAL / EYE HISTORY

Is there a family medical history of any of the following?

	Relationship
☐ Blindness	_____
☐ Cataracts	_____
☐ Corneal Problems	_____
☐ Glaucoma	_____
☐ Lazy Eye	_____
☐ Macular Degeneration	_____
☐ Retinal Problems	_____
☐ Diabetes	_____
☐ Heart Disease	_____

PATIENT MEDICAL HISTORY

Name of Family Physician _____
Date of Last Physical Check-up _____

CURRENT MEDICATIONS (Rx or Over the Counter)
List name of medications including eye drops, vitamins and birth control pills _____
_____
Allergies to medications: ☐ Yes ☐ No
_____

Have you ever been diagnosed or treated for the following?

☐ Allergies ☐ Cholesterol ☐ Kidney
☐ Asthma ☐ Diabetes ☐ Nerves
☐ Arthritis ☐ Heart Disease ☐ Thyroid
☐ Cancer ☐ High Blood Pressure
Other _____

PATIENT EYE HISTORY

Date of Last Eye Exam _____
By Whom? _____
Do you currently wear contact lenses? ☐Yes ☐No
What kind? _____
Solutions used _____
Would you prefer clear contact lenses, or colored contact lenses to change the color of your eyes? _____
Have you ever tried contact lenses? ☐Yes ☐No

Do you….. (Check box if your answer is yes)

☐..Work at a computer?
☐..Think you might benefit from thinner, lighter lenses?
☐..Spend time outdoors? (how much?) _____Hrs/week
☐..Have prescription sunglasses?
☐..Prefer not to wear your glasses at times?
☐..Want information on Laser Vision Correction surgery?
☐..Have more than 1 pair of current Rx glasses?
☐..Have children?
☐..Have family members in need of eye care?
If you wear bifocals, do the lines or head tilting bother you?
☐ Yes ☐ No
If you wear contact lenses, are you satisfied with the vision and comfort? ☐ Yes ☐ No

Have you ever been diagnosed or treated for the following?

☐ Cataracts ☐ Iritis/Uveitis
☐ Corneal Abrasion ☐ Lazy Eye
☐ Eye Infection ☐ Macular Degeneration
☐ Eye injury ☐ Retinal Detachment
☐ Glaucoma ☐ Other eye disorders

Do you experience or have you ever experienced?

☐ Blurry vision ☐ Flash of light ☐ Sunlight sensitivity
☐ Burning ☐ Floater/spots ☐ Crossed eye/eye turn
☐ Tearing ☐ Grittiness ☐ Trouble seeing at night
☐ Headaches ☐ Itchiness ☐ Uncomfortable glasses
☐ Double vision ☐ Occasional Dryness