



Geneva Eye Care Inc Welcome Back To Our Office

Welcome to Geneva Eye Care Inc. 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 Home Phone - Include Area Code Day Phone Phone Type

 Date of Birth Guardian (if under 18) Email Address

 Emergency Contact Relationship Emergency Phone

How were you referred to our office?

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

Who were you referred by?

Race

<input type="checkbox"/> American Indian Or Alaska Native	<input type="checkbox"/> Native Hawaiian Or Other Pacific Islande
<input type="checkbox"/> Asian	<input type="checkbox"/> White
<input type="checkbox"/> Black Or African America	<input type="checkbox"/> Declined To Specify
<input type="checkbox"/> Hispanic Or Latino	

Other Race

Ethnicity Hispanic Or Latino Not Hispanic Or Latino Not Disclosed Filipino

Preferred Language English Chinese Dutch; Flemis French Germa Hindi

Height	ft	in	cm/m	<input type="radio"/> ft in	<input type="radio"/> cm	<input type="radio"/> m	Weight	<input type="radio"/> lbs	<input type="radio"/> kg
<input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/>

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.

I Authorise the release of information to all my insurance companies and my doctor to act as my agent in helping me obtain payment direct to my doctor.

Signature

Date

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	<input type="radio"/> Yes <input type="radio"/> No	Respiratory (Asthma)	<input type="radio"/> Yes <input type="radio"/> No	Anxiety or Depression	<input type="radio"/> Yes <input type="radio"/> No
Weight Loss	<input type="radio"/> Yes <input type="radio"/> No	Gastrointestinal	<input type="radio"/> Yes <input type="radio"/> No	Thyroid, Diabetes	<input type="radio"/> Yes <input type="radio"/> No
Other Symptoms	<input type="radio"/> Yes <input type="radio"/> No	Kidney	<input type="radio"/> Yes <input type="radio"/> No	Blood/Lymph	<input type="radio"/> Yes <input type="radio"/> No
Ears,Nose,Throat	<input type="radio"/> Yes <input type="radio"/> No	Muscles,Bones, Joints	<input type="radio"/> Yes <input type="radio"/> No	Allergic	<input type="radio"/> Yes <input type="radio"/> No
Cardiovascular (high blood pressure etc.)	<input type="radio"/> Yes <input type="radio"/> No	Skin	<input type="radio"/> Yes <input type="radio"/> No	Pregnant	<input type="radio"/> Yes <input type="radio"/> No
Neurological (Multiple Sclerosis)	<input type="radio"/> Yes <input type="radio"/> No			Nursing	<input type="radio"/> Yes <input type="radio"/> No

FAMILY HISTORY

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

SOCIAL HISTORY

Current Occupation : _____ Since _____ 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 visual difficulty when driving? Yes No Do you have glare problems? Yes No

Do you have problems with night vision? Yes No

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

Do you currently wear contact lenses? Yes No Since _____

How many hours/day ? _____ How many days/week ? _____

SPECTACLE LENS HISTORY

Do you currently wear glasses ? Yes No Since _____ FullTime PartTime Distance Close

Glasses Owned SingleVision Bifocals Trifocals Backup Safety Sports Progressive

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

Have you had trouble in the past with Bifocals? 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)

SOCIAL HISTORY

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

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

Do you engage in regular exercise? Yes No

Hobbies/ Interests : _____

CONTACT LENS HISTORY

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

*If wearing Contact Lenses -

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

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

Lens Comfort

Right	Left	Distance Vision	Right	Left	Near Vision	Right	Left
_____	_____	_____	_____	_____	_____	_____	_____

What Solutions do you use? Cleaner _____ Disinfectant _____ Enzyme _____