



# Patient Questionnaire (Refractive)

Welcome to Eye 1<sup>st</sup> Vision & Laser. Please take your time to complete the following questions; this will help us assess your vision health. Please use black ink only and complete the entire form. If you leave a line blank, please initial with "N/A". In accordance with FTC Identity Theft Rule 16 CFR 681:2, please present a Photo ID with current address for photocopying. Additionally, for insurance purposes, we will need to make a copy of your insurance card(s).

Thank you.

## PERSONAL

First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Last Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Main Phone \_\_\_\_\_ Please Circle: HOME CELL WORK

Alternate Phone \_\_\_\_\_ Please Circle: HOME CELL WORK

E-Mail Address \_\_\_\_\_ Sex: Male Female

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Social Security Number For Insurance Verification \_\_\_\_\_

Marital Status \_\_\_\_\_ Do you have any children? Y N If YES, how many? \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ Relation \_\_\_\_\_ Phone \_\_\_\_\_

## REFERRAL SOURCE (Please be specific)

How did you hear about Eye 1<sup>st</sup> Vision & Laser? \_\_\_\_\_

## ACTIVITY

What is your occupation? \_\_\_\_\_  Active  Retired  Student

How do you spend your day? \_\_\_\_\_

What do you do for recreation? \_\_\_\_\_

## VISION

What is the purpose of your visit to Eye 1<sup>st</sup> Vision & Laser? \_\_\_\_\_

Has your prescription changed in the last year? Y N Has your vision been stable in the last year? Y N

Are you seeing clearly through your glasses? Y N Are you seeing clearly through your contacts? Y N

Type of contacts you wear? Please Circle: Soft Toric RGP Cosmetic Bifocal Do you wear them overnight? Y N

Have you ever had any of the following? Please Circle: Retinal Detachment Glaucoma Herpes Keratitis Uveitis

Keratoconus Dry Eyes Severe Eye Injury Eye Surgery Cataracts Contact Lens Related Problems

Please list any regular eye drops you use: \_\_\_\_\_

(Continued)

**MEDICAL REFERRAL**

Who is your Optometrist? (Eye Doctor) \_\_\_\_\_ Ophthalmologist? (Eye Surgeon) \_\_\_\_\_

**MEDICAL**

Do you have any significant medical history? Please Circle: Arthritis Cancer Diabetes Heart Disease HIV Stroke

Connective Tissue Disease (e.g. Lupus) Other: \_\_\_\_\_

Please list any prescription medications: \_\_\_\_\_

Have you ever consulted a Psychiatrist? Y N If YES, for how long? \_\_\_\_\_

Do you have the following? Please Circle: Claustrophobia Severe Anxiety Type "A" Personality

Do you have allergies to medications, eye drops, contact sensitivity or latex? Y N

If YES, please list \_\_\_\_\_

Please list any family members that wear glasses or contacts: \_\_\_\_\_

**INSURANCE**

Name of Employer \_\_\_\_\_ Phone \_\_\_\_\_

Employer Address City State Zip \_\_\_\_\_

Primary Vision Insurance Company \_\_\_\_\_ Are you the policyholder? Y N

If NO, Name of Policy Holder \_\_\_\_\_ Relation \_\_\_\_\_ DOB \_\_\_\_\_

Primary Health Insurance Company \_\_\_\_\_ Are you the policyholder? Y N

If NO, Name of Policy Holder \_\_\_\_\_ Relation \_\_\_\_\_ DOB \_\_\_\_\_

**PRIVACY PRACTICE**

A copy of our Privacy Practices (HIPAA) is available to all patients. I would like a copy of this notice: Y N

**AUTHORIZATION TO RELEASE MEDICAL INFORMATION**

I authorize Dr. (Your Optometrist and/or Ophthalmologist ) \_\_\_\_\_ to disclose complete information to Eye 1<sup>st</sup> Vision & Laser concerning medical findings and treatment of the undersigned.

**PATIENT SIGNATURE**

I hereby declare and represent that the foregoing statements and particulars are, to the best of my knowledge and recollection, complete and that I have not willfully concealed or misrepresented any material fact or circumstance concerning this information or the subject thereof:

PRINT NAME \_\_\_\_\_

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

Parent or Guardian Signature (If Applicable) \_\_\_\_\_ Date \_\_\_\_\_