Welcome to Our Practice

PATIENT INFORMATION

Full Name ____________________ Birthdate ____________

Street Address ____________________ City ________ State ______ Zip ______

Mailing Address (if different) ____________________

Home Phone ____________________ Social Security # ____________________

Cell Phone ____________________ Email Address ____________________

Check Appropriate Boxes ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Male ☐ Female

Employer ____________________ Occupation __________ Work Phone __________

Spouse's Name ____________________ Employer __________ Work Phone __________

If you are a new patient, how did you hear about Reed Eye Associates? ☐ Friend ☐ Yellow Pages ☐ Web Site ☐ Advertisement ☐ MD Other ____________________

INSURANCE INFORMATION

Primary Insurance ____________________ Contract # ____________________

Subscriber's Name ____________________ Subscriber's Birthdate ____________________

Secondary Insurance ____________________ Contract # ____________________

Subscriber's Name ____________________ Subscriber's Birthdate ____________________

Primary Care Physician ____________________ Referring Physician (if different) ____________________

For patients under 19, or if you are covered under parent's insurance:

Father's Name ____________________ Social Security # ____________________

Employer ____________________ Work Phone ____________________

Mother's Name ____________________ Social Security # ____________________

Employer ____________________ Work Phone ____________________

Please note that all fees and copayments are due at the time of your visit and can be paid by cash, check or credit card. If you pay by check and it is returned for any reason, you will be charged a $15.00 service charge.

RELEASE OF INFORMATION

I assign all medical/surgical benefits to Reed Eye Associates for services performed by Reed Eye Associates staff and authorize the release of information concerning my care to the health insurance agency listed above.

I understand and agree that, regardless of insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. Furthermore, I understand that if my account is turned over for collection that I will be responsible for all fees and expenses incurred by any collection agency or attorney.

SIGNED ____________________ Date ____________________

Patient/ Guardian/ Responsible Individual - must be 18 or older to sign

MEDICAL HISTORY QUESTIONNAIRE

Name ______________________ DOB __________ Date __________

List all medications you currently take (prescription and over-the-counter)

____

____

Do you have allergies to any medications? Y / N If yes, please list __________

List all major illnesses or injuries ______________________________

____

List any surgeries you have had ______________________________

____

Date of last eye exam __________ Do you drive? Y / N

Do you wear contact lenses? Y / N Do you wear glasses? Y / N

Occupation ____________________ Hobbies ____________________

Do you smoke? No / Yes-how much? ________ / day How long? __________ years

Are you having any problems with your eyes? Y / N If yes, please explain __________

____

____

GENERAL (if yes, explain in space provided)

		Explanation
Ears, Nose, Throat (sinus, cough, dry mouth, etc.)	Y / N	
Cardiovascular (heart, blood pressure, stroke, etc.)	Y / N	
Respiratory (asthma, emphysema, etc.)	Y / N	
Gastrointestinal (stomach ulcers, intestinal, etc.)	Y / N	
Genital, Kidney, Bladder	Y / N	
Muscles, Bones, Joints (arthritis, etc.)	Y / N	
Skin (acne, warts, skin cancer, etc.)	Y / N	
Neurological (multiple sclerosis, headaches, seizures, etc.)	Y / N	
Endocrine (diabetes, thyroid, etc.)	Y / N	
Blood, Lymph (high cholesterol, anemia, etc.)	Y / N	
Allergic, Immunologic (hay fever, lupus, etc.)	Y / N	
General Health (fever, weight gain or loss, unusually tired)	Y / N	
Psychiatric (depression, anxiety, etc)	Y / N	

FAMILY HISTORY (Parents, siblings, grandparents)

Blindness	Y / N	Glaucoma	Y / N	Hypertension	Y / N
Macular Degeneration	Y / N	Diabetes	Y / N	Heart Disease	Y / N

Other Serious Diseases? ______________________________

Eye Doctor's Signature ____________________ Date__________

PATIENT INFORMATION/LIFESTYLE QUESTIONNAIRE

Our goal at Reed Eye Associates is to provide our patients with quality eyewear that will meet all of their lifestyle needs. Over the years there have been major advances in frame and lens technologies. With these advances we are given the opportunity to better assist our patients in purchasing eyewear that will perform to their expectations yet be comfortable and stylish.

In helping us we ensure that the eyewear you receive will enable you to successfully perform all of your daily activities; whether it is for work or play, we request that you fill out this brief questionnaire. This information will allow us to better assist you in making the eyewear choices most beneficial to your lifestyle.

Name: ____ Date Completed: ___________________________

Occupation: ____ Age: _____ Sex: ☐ Male ☐ Female

1. What recreational hobbies or activities do you enjoy? Check all that apply.
   ☐ Golf ☐ Running ☐ Racquetball ☐ Football
   ☐ Tennis ☐ Snow Skiing ☐ Baseball/Softball ☐ Boating
   ☐ Water Sports ☐ Fishing ☐ Basketball ☐ Other ___________________________

2. What interests and hobbies do you enjoy? Check all that apply.
   ☐ Reading ☐ Gardening ☐ Knitting ☐ Crafts
   ☐ Watching TV ☐ Cooking ☐ Video Games ☐ Painting
   ☐ Internet ☐ Sewing ☐ Woodworking ☐ Other ___________________________

3. What job requirements do you have? Check all that apply.
   ☐ Computer Work ☐ I Work Outdoors
   ☐ Considerable Reading ☐ My Job Necessitates Safety Eyewear
   ☐ I Work Under Fluorescent Lighting ☐ Other ____

4. Are you experiencing any difficulties with your glasses and/or contact lenses with these activities? Check all that apply.
   ☐ Glare ☐ Inconsistent Vision
   ☐ Fogging ☐ Other: _______________________________
   ☐ Constant Adjustment _____________________________________

5. Are your lenses scratched or damaged from regular use? ☐ Yes ☐ No
6. Do you spend more than two hours a day viewing a computer screen? ☐ Yes ☐ No
7. Do you consider yourself sensitive to sunlight? ☐ Yes ☐ No
8. Do you spend more than one hour a day in the sun? ☐ Yes ☐ No
9. Do you have difficulties driving at night? ☐ Yes ☐ No
10. Are your current glasses uncomfortable or cause indentations on your nose? ☐ Yes ☐ No
11. Would thinner lighter lenses appeal to you? ☐ Yes ☐ No
12. Would you like a frame style change? ☐ Yes ☐ No
13. List "designer" labels you include in your wardrobe.
   ____ ____
   ____ ____
14. Which statement(s) best describe yourself?
   ☐ I lead an active lifestyle (exercise and recreation). ☐ I try to keep up with the latest fashion trends.
   ☐ I enjoy being outdoors as much as possible. ☐ I am allergic to nickel products.