Welcome to Ideal Eyes

www.IdealEyes.info (schedule, specials)
www.patientfusion.com (secure messaging, requesting appointments)

Patient: ____ Date: ______________
Last, first, middle

Phone (home/cell) ____ Okay to leave messages? Y/N

Email (reminders, invoices, specials, updates):____

Street address: ____

City: ____ State: ________ Zip: ______________

Male/Female: ____ Birth date: ____________ Age: ______ Single/Married/Divorced SSN (last 4)__________

Employer ____________________Phone: ______________ Occupation, hobbies: ____________________

Spouse/Parents/Emergency Contact: ______________________________Phone: ______________

Who may we thank for referring you? Phonebook/location/friend/family/mailing:______________________

Please initial that you have had an opportunity to review the Privacy Policies, Exam Charges, Policies, Offers. ________
Payment is expected at the time of service and when products are ordered. If you wish to discuss charges, please ask.
I understand that I am responsible for paying for services such as refractions (Medicare) and contact lens fittings (Tricare)since they are usually not be covered by my insurance.______________________

Insurance Information

Please list medical (for eye conditions like dry eyes, cataracts, etc.) and vision insurances (for routine eye exams for glasses or contacts. Please provide cards and drivers license for us to copy. Thank you.

Vision insurance: ____________________Cardholder: ____________________Policy numbers: ____________

Medical insurance:____________________ Cardholder: ____________________Policy numbers: ____________

Medical insurance:____________________ Cardholder: ____________________Policy numbers: ____________

Assignment of Insurance Benefits

The undersigned authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I agree that my signature authorizes Eye Works, Inc./DBA Ideal Eyes to submit claims for benefits for services rendered or to be rendered, without obtaining my signature on each one.
I hereby authorize my insurance company(ies) to pay and hereby assign directly to Eye Works, Inc./Ideal Eyes all benefits, if any, otherwise payable to me for the services as described on the attached forms. I understand I am financially responsible for all charges incurred. Any insurance benefits, when paid to and received by Eye Works, Inc./Ideal Eyes will be credited to my account.
Authorized signature of subscriber: ______________________________________Date: ______________

Thank you for coming!

Name ______________________________ Date__________ Race/Ethnicity: _____________

Main reason for visit: GLASSES CONTACTS MEDICAL________________________________

Glasses options of interest: DIGITAL LENSES (high definition) THINNER ANTI-REFLECTION SCRATCH RESISTANCE EASIER CLEANING EXTRA PAIR FOR COMPUTER/SUN COMPUTER LIGHT PROTECTION DARKENING OUTDOORS OTHER:______________

Visual symptoms: BLUR (right/left) (far/near/computer distance) (gradual/sudden) DOUBLE VISION
Medical symptoms: BURNING GRITTY ITCHING DRYNESS REDNESS WATERING DISCHARGE FLOATERS FLASHES POOR NIGHT VISION LIGHT SENSITIVITY DIABETIC OTHER: ____________

Eye conditions: CATARACT RETINAL DETACHMENT DRYNESS MACULAR DEGENERATION GLAUCOMA EYE TURN LAZY EYE OTHER:______________________

Eye surgeries: ______________________________**Injuries**: ____________________

Contacts: Brand: __________________ Power: R___________L___________BC/Diam _______
Do you want to stay with this brand? YES NO How often do you replace them? Every ____________
Overnight wear? YES NO Solutions? OPTI-FREE BIOTRUE COMPLETE CLEAR CARE __________

Eye drops: ____

Dilation: YES NO Dilation enlarges the pupils to allow a wider view of the health inside your eyes. It can cause blurring and light sensitivity.

Photos: YES NO Digital imaging to document your current eye health and for early findings of macular degeneration, glaucoma, diabetic retinopathy, etc. There is an additional charge for screenings. For medical indications we submit to your medical insurance.

MEDICAL

Allergies to drugs/environment/foods:_______________________________________
Severity: very mild/mild/moderate/severe Reaction: rash/breathing/nausea/other:___________

Medications (including non-prescription, supplements & dosages):____________________
____

Major surgeries/hospitalizations/events:____

Medical Conditions: DIABETES THYROID HYPERTENSION HIGH CHOLESTEROL HEART VASCULAR CANCER LUNG/ASTHMA/BREATHING ARTHRITIS MUSCLE ACHES EAR/NOSE/SINUS STOMACH/INTESTINAL HEADACHES/NEUROLOGICAL/ SEIZURES MENTAL/DEPRESSION WEIGHT CHANGE FATIGUE OTHER:________________
____

Family medical history or **eye conditions**: DIABETES GLAUCOMA MACULAR DEGENERATION CATARACTS BLINDNESS OTHER______________________________________

Social History: Smoking currently? Y / N Past? Y / N Packs or cig./day? ________ Alcohol use:_____

Thank you!