

Welcome to Eye Works, Inc.

www.eyeworksrapidcity.com (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: _____

Spouse/Parents/Emergency Contact: _____ Phone: _____

Who may we thank for referring you? Phonebook/location/friend/family/mailling: _____

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.

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. 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. 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. 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.

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!