WELCOME TO EXPERIENCE YOUR EYE SPECIALIST revised 11-07

We'll Strive to Exceed Your Expectations, it's that Simple!

Name ____________________ Date of Birth ______________ Age ______ Sex: M ( ) F ( ) Date______________

Street______________________________ City______________________ State______ ZIP______________

Home Phone____________________ Work Phone____________________ Cell Phone____________________

Any problems with your current glasses or contacts? ____

Occupation ____________________ Employer ____________________ Primary Care Physician ____________________

Do You:	Yes	No	Do You:	Yes	No
Work at a computer ?	( )	( )	Have Prescription Sun wear?	( )	( )
Spend time outdoors?	( )	( )	Prefer not to wear your glasses?	( )	( )
Have more than 1 pair of current RX eyewear?	( )	( )	Want information on Laser Surgery?	( )	( )
Have Children?	( )	( )	Interest in trying contact lenses?	( )	( )
Have family members in need of eye care?	( )	( )	Want thinner and lighter lenses?	( )	( )

HAVE YOU EVER HAD OR ARE YOU CURRENTLY BEING TREATED FOR ANY OF THE FOLLOWING:

	Yes	No		Yes	No
High Blood Pressure	( )	( )	Flashes of Light	( )	( )
Diabetes	( )	( )	Floaters	( )	( )
Heart Condition	( )	( )	Vision Loss	( )	( )
Breathing Problems	( )	( )	Eye Injury	( )	( )
Cancer	( )	( )	Eye Surgery	( )	( )
Thyroid Disease	( )	( )	Eye Infections	( )	( )
Stroke	( )	( )	Double Vision	( )	( )
Frequent Headaches	( )	( )	Lazy Eye	( )	( )
Glaucoma	( )	( )	Allergies	( )	( )
Arthritis	( )	( )	Currently Pregnant	( )	( )
HIV	( )	( )	Tobacco Use	( )	( )
Cataracts	( )	( )	Alcohol/Drug Use	( )	( )

Does Anyone In Your Immediate Family Have:

	Yes	No		Yes	No
Glaucoma	( )	( )	Blindness	( )	( )
Diabetes	( )	( )	Macular Degeneration	( )	( )

Do you experience:	Never	Slight	Moderate	Severe
Gritty or sandy sensations?	( )	( )	( )	( )
Pain or soreness?	( )	( )	( )	( )
Fluctuating Vision?	( )	( )	( )	( )
Occasional tearing?	( )	( )	( )	( )
Blurred vision while reading ?	( )	( )	( )	( )
Discomfort in windy conditions?	( )	( )	( )	( )
Itching?	( )	( )	( )	( )
Discomfort in air conditioned areas?	( )	( )	( )	( )

Medicines You Currently Take: 1.______________ 2.______________ 3.______________ 4.______________ 5.______________

Do You Currently Wear Contacts? Yes ( ) No ( ) If Yes, Type Worn ____________________ Solutions Used______________

Are you satisfied with the vision and comfort of your contact lenses? Yes ( ) No ( ) Daily Wearing Time (Hours Per Day) ____________

Who may we THANK for referring you to our office?____________________ If not referred, how did you choose our office?

( ) Newspaper ( ) Yellow Pages ( ) Web page ( ) Primary Care Physician ( ) Other ____________________

PLEASE READ CAREFULLY

CONSENT FOR RELEASE OF INFORMATION, RESPONSIBILITY FOR PAYMENT, AND ACKNOWLEDGEMENT OF NPP.

I acknowledge that I have received a copy of Experience Your Eye Specialist, PLC (E.Y.E.S., PLC) Notice of Privacy Practices

I am responsible for payment at the time of each visit for all services provided by E.Y.E.S., PLC not covered by an insurer. My signature serves as a "signature on file" for claim processing and for release of medical information to my insurance carrier(s).

Name of Vision Insurance____________________ Name of Health Insurance____________________ Group #______________

Insured ID #____________________ Insured Date of Birth______________ Insured Name ____________________

Medi Care ID# ______________________________ Medicaid ID #______________________________

I understand that this consent for release or disclosure of specific information in my medical records can be revoked or restricted if I request such restriction in writing to this office. I also understand that my request for restriction may be denied if the information restricted is required for health care operations.

Signature______________________________ (Self, Parent, POA or Guardian) Today's Date______________20____

Initials__________ Date__________20____ Initials__________ Date__________20____ Initials__________ Date__________20____