WELCOME TO EXPERIENCE YOUR EYE SPECIALIST

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

Name ______________________ Date of Birth ______________ Age ______ Sex: M F Date______________

Street______________________ City______________________ State_____ ZIP______________

Phone Number- HOME: ______________________ □ **Preferred number to contact**

CELL PHONE: ______________________ □ **Preferred number to contact** □ **Receive texts for reminders & appointments**

Email:______________________ □**Preferred method of contact**

Occupation : ______________________

Who may we thank for referring you to our office? Web page Insurance Primary Care Physician **Other:**______________

Do you currently wear GLASSES? Yes No

Is there anything you wish you could change about your current glasses?

Circle all that apply: Thinner lenses Reduce glare Update look/frame Comfort of glasses One pair not working in all situations Want lenses to change into sunglasses (transitions) Other: ______________

Do you currently wear contacts? Y N **Are you interested in wearing contacts?** Y N

What brand of CONTACTS are you currently wearing? ______________________

****CURRENT MEDICATIONS:** 1.__________ 2.__________ 3.__________ 4.__________

5.__________ 6.__________ 7.__________ 8.__________

**** PRIMARY CARE DOCTOR: (FIRST AND LAST NAME)** ______________________

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

	Y	N		Y	N
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:

	Y	N		Y	N
Glaucoma			Blindness		
Diabetes			Macular Degeneration		

Do you experience:	Never	Slight	Moderate	Severe
Gritty or sandy sensations?				
Pain or soreness?				
Itching?				
Occasional tearing?				
Blurred vision while reading?				
Discomfort in windy conditions?				

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).

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______________