

Welcome to Dr. Jeffries' office.

Please complete the following form in its entirety.

Date: _____

Name: Last: _____ First: _____ M.I. _____ Salutation: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Age: _____ Home Phone: _____ Work Phone: _____

SS#: _____ Marital Status: _____ E-mail Address: _____

Employer: _____ Occupation: _____

How were you referred to our office?

- Friend or family member: _____
- Family Doctor: _____
- Ophthalmologist: _____
- Insurance Company
- Received mailing
- Internet
- Television
- Newspaper
- Other _____

Please list all insurances, vision and medical. Please bring all insurance cards with you to your appointment.

Primary Insurance Information	Secondary Insurance Information
Ins. Co. Name:	Ins. Co Name:
Address:	Address:
Insured's Name:	Insured's Name:
Identification #:	Identification #:
Group #:	Group #:
Insured's DOB:	Insured's DOB:
Insured's SS#:	Insured's SS#:
Patient Relation to Insured:	Patient Relation to Insured:

I, the undersigned, certify that I (or my dependent) have insurance coverage with the above company (ies) and assign directly to Amy Jeffries, O.D. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: _____

Date: _____

EYEGLASS HISTORY

- Do you wear glasses? Yes No
- Glasses Owned: single vision bifocals progressive safety glasses trifocals sports glasses backup glasses other: _____
- Computer used: Yes No Hours per day: _____ Distance from computer: _____
- Do you have problems with glare? Yes No
- Do you have problems with night vision? Yes No
- Are you allergic to nickel (eg: jewelry or eyeglass frames discoloring your skin)? Yes No
- If you currently wear eyeglasses, are there certain times when you would rather not? Yes No
- If you currently wear eyeglasses, does your spare pair have the correct prescription? Yes No
- Do you wear prescription or non-prescription sunglasses? Yes No
- Do your sunglasses have UV (ultra-violet) protection? Yes No
- Are your sunglasses your current prescription? Yes No

CONTACT LENS HISTORY

- Do you currently wear contact lenses? Yes No
- Have you ever tried to wear contact lenses? Yes No Reason for stopping: _____
- If you wear contact lenses, do your backup eyeglasses have your correct prescription? Yes No

Answer the questions below only if you currently wear contact lenses:

1. What type or brand of contacts do you wear? _____
2. How old are your contact lenses? _____
3. How often do you replace or dispose of your contact lenses? _____
4. What brand of solution do your lenses soak in overnight? _____
5. What is your typical wearing schedule? _____ hours/day _____ days/week
6. Are you having any problems with your current contact lenses? Yes No

Are you interested in being evaluated for refractive surgery? Yes No

Are you interested in wearing contact lenses? Yes No

Date of last eye exam: _____ Where did you get your last eye exam: _____

Date of last physical exam: _____ Name of Primary Care Physician: _____

MEDICAL HISTORY

Eye History: Do you suffer from any of the following?

Distance vision blur	<input type="radio"/> Yes <input type="radio"/> No	Seeing flashes	<input type="radio"/> Yes <input type="radio"/> No	Dry Eyes	<input type="radio"/> Yes <input type="radio"/> No
Near vision blur	<input type="radio"/> Yes <input type="radio"/> No	Distorted vision (haloes)	<input type="radio"/> Yes <input type="radio"/> No	Itching	<input type="radio"/> Yes <input type="radio"/> No
Middle distance vision blur	<input type="radio"/> Yes <input type="radio"/> No	Glare / Light sensitivity	<input type="radio"/> Yes <input type="radio"/> No	Red Eyes	<input type="radio"/> Yes <input type="radio"/> No
Double Vision	<input type="radio"/> Yes <input type="radio"/> No	Loss of side vision	<input type="radio"/> Yes <input type="radio"/> No	Crossed Eyes	<input type="radio"/> Yes <input type="radio"/> No
Mucous Discharge	<input type="radio"/> Yes <input type="radio"/> No	Eye pain / soreness	<input type="radio"/> Yes <input type="radio"/> No	Headaches	<input type="radio"/> Yes <input type="radio"/> No

Review of Systems: Many diseases of the body have grave eye health consequences. Please answer the following questions. While they may seem unrelated to an eye problem, it is crucial to your care that we ask them.

Do you currently have any of the following problems?	Yes	No	If YES, please explain:
Chronic fever, unexpected weight loss/gain, fatigue	<input type="radio"/>	<input type="radio"/>	_____
Ear/nose/throat problems (eg hearing loss, sinus problems, sore throat)	<input type="radio"/>	<input type="radio"/>	_____
Heart problems (eg chest pain, irregular heart beat, swelling of feet, cold hands or feet)	<input type="radio"/>	<input type="radio"/>	_____
Respiratory problems (eg shortness of breath, wheezing, coughing)	<input type="radio"/>	<input type="radio"/>	_____
Gastrointestinal problems (eg heartburn, abdominal pain, diarrhea, vomiting)	<input type="radio"/>	<input type="radio"/>	_____
Genitourinary problems (eg painful urination, blood in urine, sex organ problems)	<input type="radio"/>	<input type="radio"/>	_____
Musculoskeletal problems (eg muscle aches, joint pain, swollen joint)	<input type="radio"/>	<input type="radio"/>	_____
Skin problems (eg rashes, excessive dryness, growths or lumps)	<input type="radio"/>	<input type="radio"/>	_____
Neurological problems (eg numbness, weakness, headaches, "blackouts")	<input type="radio"/>	<input type="radio"/>	_____
Psychiatric problems (eg depression, anxiety)	<input type="radio"/>	<input type="radio"/>	_____
Endocrine problems (eg frequent urination, thirst, feeling hot or cold all the time)	<input type="radio"/>	<input type="radio"/>	_____
Blood/Lymph problems (eg bruising, weakness, unusual paleness, swollen glands) ...	<input type="radio"/>	<input type="radio"/>	_____
Immune problems (eg frequent infections, allergic reactions to foods, dust, pollens)	<input type="radio"/>	<input type="radio"/>	_____

Have you ever been treated for any medical conditions? (eg diabetes, high blood pressure, high cholesterol, arthritis, etc) Yes No
If YES, please explain: _____

Have you ever had any eye disease? (eg glaucoma, cataract, wandering or "lazy" eye, retinal detachment) Yes No
If YES, please explain: _____

Have you ever had any surgery or been hospitalized? Yes No
If YES, please explain: _____

Do you take any medications, including over the counter medicines? Yes No
If YES, please explain: _____

Do you have any food or drug allergies? Yes No
If YES, please explain: _____

Family History: Do any MEDICAL or EYE disease run in your family (BLOOD relatives) (eg diabetes, high blood pressure, cancer, glaucoma, macular degeneration, etc.)? Yes No
If YES, please explain: _____

Social History:
Do you drink alcohol? No Occasionally 1 / day 2-3 / day 4+ / day
Do you smoke or use tobacco products? No Occasionally ___ pack / day 1+ pack / day

HIPAA Protected Health Information: It is the policy of this office in accordance with the Federal HIPPA Regulation that all health information is kept strictly confidential. Please sign below in recognition that a copy of our protected health information privacy act was given to you for your review.

Signature: _____

Below For Office Use Only:

I have reviewed this information with the patient. _____ O.D. Date: _____

Reviewed on the following dates: Initials _____ Date: _____ Initials _____ Date: _____