Altoona EyeCare
EyeCare Associates of Ankeny
Johnston EyeCare

Thank you for choosing our practice for your eye care needs. Please complete this form in ink. If you have any questions, do not hesitate to ask for assistance. All information is confidential. **(Please print)**

PATIENT INFORMATION Date_____

_____ Nickname_____
First MI Last

Address_____ City_____ State_____ Zip_____

Birthdate_____ □ Male □ Female

Primary Language: □ English □ Other _____
Race: □ American Indian or Alaska Native □ Asian □ Black or African American □ Native Hawaiian or Other Pacific Islander □ White □ All Other Races □ Declined to specify
Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino □ Declined to specify
How did you hear about us? □ Facebook □ Chamber of Commerce □ Word of Mouth □ Radio Advertising □ Driving by/ saw sign □ Online Search □ Yelp □ Magazine □ Yellow Pages □ Other

Please check your preferred phone contact: ___ HOME ___ CELL ___ WORK

Home Phone #_____ Cell Phone #_____ Work Phone #_____

E-mail address_____ □ Decline

Preferred communication for your next appointment □ Email □ Text □ US Mail

Marital Status: □ Single □ Married □ Widowed □ Divorced □ Other

Employer/School_____ Occupation/Student_____ □ Full Time □ Part Time

Emergency Contact: _____ Phone #_____ Relationship _____

IF PATIENT IS A MINOR
Mother's name _____ Address _____

Home#_____ Cell#_____ Work#_____ Employer_____

Father's name _____ Address _____

Home#_____ Cell#_____ Work#_____ Employer_____

INSURANCE INFORMATION (Please provide cards upon arrival)

Insurance Company Name _____ Vision coverage: ___Yes ___No
Medical coverage: ___Yes ___ No
Name of primary insured _____ Employer _____

Birth date _____ SSN# _____ Relationship to patient _____

DO YOU HAVE ANY ADDITIONAL INSURANCE?

Insurance Company Name _____ Vision coverage: ___Yes ___No
Medical coverage: ___Yes ___ No
Name of primary insured _____ Employer _____

Birth date _____ SSN# _____ Relationship to patient _____

PLEASE COMPLETE BACK OF THIS PAGE

Health History

Date of last vision exam_____ Name of eye doctor_____

Reason for today's exam _____ Name of medical doctor_____

Do you or anyone in your immediate family have a history of the following? Please use abbreviations to identify self or family member:
S/self **M/** mother **F/**father **B/** brother **SS/**sister **GM/**grandmother **GF/**grandfather **A/**aunt **U/**uncle

_____Cataracts _____Macular degeneration _____Glaucoma _____Blindness _____Turned or lazy eye

_____Diabetes _____Heart disease or stroke _____High blood pressure _____Thyroid disease _____Lupus or MS

_____Asthma _____Lung problems _____Hay fever _____Sinus Condition _____ Arthritis

_____Cancer or tumor – Type _____ _____Skin condition _____Frequent headaches _____Hepatitis _____HIV

List all prescription medications you are currently taking_____

List vitamins or non-prescriptions medications you are currently taking_____

List known drug allergies_____ Other allergies_____

List recent surgeries (past 5 years)_____

Do you have any of the following conditions involving your eyes? Please check all that apply.

___Eye surgery ___Eye or head injury ___Severe pain ___Eye infection or disease ___Eye strain

___Poor near vision ___Poor distance vision ___Double vision ___Light sensitivity ___Halos ___Redness

___Floaters or spots ___Light flashes ___Eyes burn, itch, water ___Discharge from the eye ___Glare

If you have check any of the above, please explain_____

_____Height Do you: ____Smoke ____Consume Alcohol ____Use recreational drugs

Do you currently wear glasses? ___ Yes ___No How old are they? _____

Have you ever had difficulty adjusting to new glasses? ___ Yes ___ No Describe briefly: _____

When do you wear your glasses? ___All the time ___Reading & near work ___Distance tasks only ___Computer ___Work safety _____Sports

Do you use a computer or video display terminal? ___Yes ___No If yes, how many hours per day? _____

Do you currently have: ___2nd pair glasses (for backup or emergency) ___Sunglasses ___Sport glasses ____Work safety glasses

What hobbies or sports do you participate in?_____

Are you interested in trying contact lenses? _____ Do you wear contacts now? _____ Have you ever worn contacts? _____

If so, what style? ___Soft ___Gas permeable ___Colored What cleaning/disinfecting system do you use? _____

How many hours a day do you wear your contacts? _____ How often do you replace your contact lenses? _____

What brand of contacts are you currently wearing? _____ Are you interested in corrective eye surgery? (Lasik/Laser) _____

Authorization

I certify that the above information is accurate and complete to the best of my knowledge. I understand that providing the incorrect information can be dangerous to my health. I authorize the doctor to release any information, including the diagnosis, and the records of any treatment or examination rendered to me or my child during the period of such eye care, to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the eye doctor or ophthalmic group insurance benefits otherwise payable to me. I understand that my eye care insurance carrier may pay less than the actual bill for my services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

*X*_____ _____

Signature of patient (or parent if a minor) Date