**Thank you for choosing Eye-Mart Optical for your eye care needs!**

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| **Today’s Date** |       |

**[ ] Mr. /** **[ ] Mrs. /****[ ] Ms. /** **[ ] Dr.**

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| **Name: Last**  |       | **First** |       | **MI** |       | **Preferred Name** |       |

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| **Address**  |       | **City** |       | **State** |       | **Zip** |       |

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| **Home Phone #** |       | **Work Phone #** |       | **Cell Phone #** |       |

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| **Preferred Phone Number:** [ ] Home / [ ] Work / [ ] Cell |

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| **Email Address** |       |

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| **Birth Date**  |       | **Age** |       | **Social Security #** |       | **Occupation** |       |

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| **Marital Status:**  | [ ] Married / [ ] Single / [ ] Divorced / [ ] Widowed | **Preferred Language** |       |

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| **Race:**  | [ ] African Am / [ ] Asian / [ ] Native Indian [ ] Pacific Islander / [ ] White / [ ] Other | **Ethnicity:** | [ ] Hispanic / [ ] Not Hispanic |

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| **Have you been to Eye-Mart Optical before?**  | [ ] Yes / [ ] No  | **How did you select us?** |       |

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| **Do you have vision insurance?**  | [ ] Yes / [ ] No  |

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| **If yes:**  | [ ] VSP / [ ] Spectera /[ ] Davis /[ ] Avesis /[ ] Eyemed /[ ] Medicaid /[ ] Medicare /[ ] Other |       |

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| Subscriber Name  |       | Member ID # |       | **Member Date of Birth** Member Date of Birth |       |

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| **Do you have health insurance?**  | [ ] Yes / [ ] No  | If yes, who is it through? |       |

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| Subscriber Name  |       | Member ID # |       | **Member Date of Birth** Member Date of Birth |       |

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| **Insurance:** I authorize the exchange of information necessary for treatment, payment and healthcare operations, including the processing of insurance claims. I understand that I may have co-payments, deductibles and overage costs and ultimately I am responsible for all fees incurred. Eye-Mart Optical does not guarantee the accuracy of benefit information given to us from insurance companies. If you have questions about your coverage, please contact your insurance representative.  |

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| Patient Signature **X**  |       |  Date |       |

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| **HIPAA Notice:** I acknowledge that I have received a copy of or understand Vogue Vision’s Notice of Privacy Practices (available from our front desk). |

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| Patient Signature **X**  |       |  Date |       |

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| **Notice to Contact Lens Patients:** The contact lens fitting/evaluation fee provides you with the diagnostic contact lenses needed for your contact lens prescription to be finalized. Follow-up appointments related to your contact lenses are included in this fee for up to three months, in most cases. Professional service fees, including the examination charges and contact lens fitting fee, are non-refundable. Federal law mandates that contact lens prescriptions expire one year from the date of the fitting. |

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| **Please initial that you have read and understand:**  |       |

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| **Are you allergic to any medications?**  | [ ] Yes / [ ] No  | If yes, which medications? |       |

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| **Do you take any medications?**  | [ ] Yes / [ ] No  |  If yes, please list all (including over-the counter and eye drops) |

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**Do YOU have any of the following eye conditions?**

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| [ ] Blurry Vision | [ ] Eye Pain | [ ] Double Vision | [ ] Dry Eyes |
| [ ] Eye Itching | [ ] Lazy Eye | [ ] Prior Eye Surgery | [ ] Eye Burning |
| [ ] Flashes / Floaters | [ ] Discharge | [ ] Eye Redness |  |

**Do YOU have any of the following medical conditions?**

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| --- | --- | --- | --- |
| [ ] Seasonal Allergies | [ ] Hormone Dysfunction |  |  |
| [ ] Rheumatoid Arthritis | [ ] Glaucoma | [ ] Fibromyalgia |  |
| [ ] Lupus | [ ] Cataracts | [ ] Muscular Dystrophy | [ ] Heart Disease |
| [ ] Crohn’s Disease | [ ] Macular Degeneration | [ ] Osteoarthritis | [ ] High Blood Pressure |
| [ ] Colitis | [ ] Multiple Sclerosis | [ ] Develop. Disability | [ ] Stroke |
| [ ] Stomach Ulcers | [ ] Epilepsy | [ ] Extreme Weight Loss | [ ] High Cholesterol |
| [ ] Depression | [ ] Alzheimer’s | [ ] Fever | [ ] STDs |
| [ ] Panic Disorder | [ ] Parkinson’s | [ ] Trauma | [ ] Asthma |
| [ ] Schizophrenia | [ ] Eczema | [ ] Anemia | [ ] Emphysema |
| [ ] Diabetes | [ ] Rosacea | [ ] Leukemia |  |
| [ ] Thyroid Dysfunction | [ ] Psoriasis |  |  |

**Does anyone in your FAMILY have any of the following conditions?**

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| --- | --- | --- |
| [ ] Glaucoma | [ ] Macular Degeneration | [ ] Cataracts |
| [ ] Other Eye Problems | [ ] High Blood Pressure | [ ] Diabetes |

**Social History:** This information is confidential. However, you may discuss this directly with the doctor, if you prefer.

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| Do you use tobacco products? [ ] Yes / [ ] No | If yes, what type? Amount? How long? |       |
| Do you drink alcohol? [ ] Yes / [ ] No | Do you use illegal drugs? [ ] Yes / [ ] No |
| Have you been infected with HIV, Gonorrhea, or Hepatitis? [ ] Yes / [ ] No |

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| **When was your last eye exam?**  |       | **What office?** |       | **Member Date of Birth Were you dilated?** [ ] Yes / [ ] No |

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| **Do you wear contact lenses?** [ ] Yes /[ ] No | **What kind?** |       | **Member Date of Birth Do you want a contact exam today?** [ ] Yes /[ ] No |

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| **Are you currently pregnant or nursing?** [ ] Pregnant / [ ] Nursing / [ ] No | **Member Date of Birth Are you interested in LASIK?** [ ] Yes / [ ] No |

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| **Pupil Dilation Consent:** In order to fully determine the health of the eyes, pupil dilation may be necessary. Some eye diseases are found in the periphery of the eye and pupil dilation makes it easier to see the periphery. If the doctor decides to dilate, eye drops are used to enlarge the pupils. This may cause sensitivity to light and blurry near vision for 4-6 hours. People usually do not have problems driving after pupil dilation. |

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| **Please initial:** I Accept Pupil Dilation, if necessary  |       |  OR I Refuse Pupil Dilation |       |