AURORA EYECARE
HEALTH. VISION. STYLE

WELCOME TO OUR OFFICE

Patient Information

Please print
Today's Date _____

Last _____
First _____ MI_____
Preferred Name_____
Date of Birth _____Age _____
Sex M F
Social Security Number_____
Street _____
City _____ State _____
Zip Code _____
Home Phone (_____)_____
Work Phone (_____)_____
Cell Phone (_____)_____
Email Address _____
How do you prefer to be contacted?
(Indicate #1 and #2 Choice):
Home #___Work #___Cell #___Text___Email____
Employer (or School) _____
Occupation (or Grade) _____
Spouse (or Parent's Name) _____
Spouse (or Parent's Employer) _____

What is the major purpose of this visit?

_____
Any problems with your current contact lenses or glasses?_____
_____

VERY IMPORTANT! NEW PATIENTS ONLY:

Who may we thank for referring you to our office?
Name of friend or relative _____

If not referred, how did you choose our office?
❑ Another Dr.
❑ Insurance List
❑ Saw Sign/Building
❑ Newspaper/Radio/TV
❑ Yellow Pages: Which directory? _____
❑ Web Page: Which Web Site? _____
❑ Other _____

Insurance Information

Vision Insurance_____
Subscriber Name_____
Subscriber SSN_____
Subscriber Birth Date_____

Primary Medical Insurance_____
Subscriber Name_____
Subscriber SSN_____
Subscriber Birth Date_____

Please be advised if you are using insurance coverage for today's visit, this is a contract between you and your insurance company...not Aurora Eye Care.

If your insurance company has not reimbursed our office in full within 90 days, you are responsible for providing payment in full to Aurora Eye Care.

Lifestyle Questions

Do you……(check box if your answer is yes)
❑..work at a computer?
❑..think you might benefit from thinner, lighter lenses?
❑..have interest in a "test drive" of the latest contact lens designs
❑..spend time outdoors? How much? ___Hrs/week
❑..have prescription sunwear?
❑..prefer not to wear your glasses at times?
❑..want information on Laser Vision Correction surgery?
❑..play any sports?
❑..have any hobbies that may require unique eyewear/lenses?
❑..have more than 1 pair of current Rx eyewear?
❑..have children?
❑..have family members in need of eyecare?

Have you ever experienced, been diagnosed or treated for any of the following ocular conditions?

❑ Blurry Vision	❑ Burning
❑ Cataracts	❑ Corneal Abrasions
❑ Crossed eye/Eye turn	❑ Double Vision
❑ Eye Infections	❑ Eye Injury
❑ Flash of light	❑ Floaters/Spots
❑ Glaucoma	❑ Grittiness
❑ Headaches	❑ Iritis/Uveitis
❑ Itchiness	❑ Lazy Eye
❑ Macular Degeneration	❑ Occasional dryness
❑ Retinal Detachment	❑ Sunlight Sensitivity
❑ Tearing	❑ Trouble seeing at night
❑ Uncomfortable glasses	

❑ Other eye disorders_____

The information in this confidential case history form is critical to the evaluation of your vision and health.

Patient Medical History

Name of Family Physician_____
City_____
Date of Last Physical Check-up_____

CURRENT MEDICATIONS (Rx or Over the Counter)
(List name of medications including eye drops, vitamins, & birth control pills)_____
_____
_____

Allergies to medications? ❑ Yes ❑ No
If so, what medications?_____
_____

Have you had any surgeries? ❑ Yes ❑ No

Do you use cigarettes/tobacco, alcohol, or other substances? ❑ Yes ❑ No

Have you ever been diagnosed or treated for the following health problems?	**Yes**	**No**
Allergies	❑	❑
Arthritis	❑	❑
Blood/Lymph	❑	❑
Bronchitis	❑	❑
Cancer	❑	❑
Cardiovascular (Heart)	❑	❑
Cholesterol	❑	❑
Diabetes	❑	❑
Digestive	❑	❑
Ears/Nose/Throat	❑	❑
Endocrine	❑	❑
Eczema/Rashes	❑	❑
Fatigue	❑	❑
Fevers	❑	❑
Genitourinary	❑	❑
High Blood Pressure	❑	❑
Integumentary (Skin)	❑	❑
Kidney	❑	❑
Muscle/Bone	❑	❑
Neurological	❑	❑
Psychological	❑	❑
Respiratory	❑	❑
Sinus	❑	❑
Throat Infections	❑	❑
Thyroid	❑	❑
Unusual weight losses/gains	❑	❑

Patient Eye History

Date of Last Eye Exam_____
By Whom?_____

Have you ever tried contact lenses? ❑ Yes ❑ No

Do you currently wear contact lenses? ❑ Yes ❑ No
What kind?_____
Solutions used_____

Are you satisfied with the vision and comfort of your contact lenses? ❑ Yes ❑ No

Family Medical/Eye History (Check all that apply)

Is there a family medical history of any of the following:
❑ No ❑ Yes (Please check boxes)

	Relationship (Mother's or Father's side)
Blindness	❑_____
Cataracts	❑_____
Corneal Problems	❑_____
Diabetes	❑_____
Glaucoma	❑_____
Heart Disease	❑_____
Lazy Eye	❑_____
Macular Degeneration	❑_____
Retinal Problems	❑_____

Signature

I HAVE READ AND UNDERSTAND THE CONSENT FORM AND CONSENT TO THE USE AND DISCLOSURE OF MY HEALTH INFORMATION FOR THE PURPOSE OF TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

_____
Patient Signature (Guardian if Minor) Date

If patient guardian is signing, please describe your relationship_____