WELCOME TO OUR OFFICE

Patient Information

Today's Date:_______________________________
Last ____
First _____________________MI _______________
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____
Patient's SSN _______________________________
Employer (or School) _________________________
Occupation (or Grade) ________________________
Spouse (or Parent's Name) ____________________
Spouse (or Parent's Work) ____________________
Date of Birth ___________________Age ________
Sex M F

What is the major purpose of this visit?

____

____

Any problems with your current contact lenses or glasses?

____

The mission of Edgewater Eyecare is to contribute to a lifetime of healthy vision, proving each patient with the highest quality vision care and consequent quality of life. We will seek continuing education to remain at the forefront of our profession and will offer the latest eye care technology, professional services, and products. The visual needs and wellness of each patient will always be our first priority. Everything we do shall communicate this.

Insurance Information

Please note that insurance does NOT cover the Contact Lens Follow-Up Evaluation.

Vision Insurance__________________________________
Subscriber Name__________________________________
Subscriber SSN___________________________
Subscriber Birth Date_____________________________

Primary Medical Insurance_________________________
Subscriber Name__________________________________
Subscriber ID_____________________________
Subscriber Birth Date_____________________________

Do you participate in a flex spending account?
❑ Yes ❑ No
How will you settle your account today?
❑ Cash ❑ Check ❑ Credit Card

Lifestyle Questions

Do you……(check box if your answer is yes)

❑..work at a computer? If so how many hours ___hrs/day
❑..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?
❑..have interest in a non-surgical approach to vision correction?
❑..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?

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

EDGEWATER EYECARE, 75 River Rd, 2nd Fl, Edgewater, NJ 07020 Ph: 201-340-6406

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__________________________
Town__________________________
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	❑	❑
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
Would you prefer clear contact lenses or color contact lenses? ❑ Clear ❑ Color
Do you prefer wearing multifocal contact lenses instead of progressive or bifocal glasses? ❑ Yes ❑ No

Family Medical/Eye History (Check all that apply)

Is there a family medical history of any of the following:
Relationship (Mother's or Father's side)

Blindness ❑__________________________
Cataracts ❑__________________________
Corneal Problems ❑__________________________
Diabetes ❑__________________________
Glaucoma ❑__________________________
Heart Disease ❑__________________________
Lazy Eye ❑__________________________
Macular Degeneration ❑__________________________
Retinal Problems ❑__________________________

Retina Evaluation (check preference)

At Edgewater Eyecare as part of our standard of care, we include a retinal photo for $10 per every comprehensive eye exam (not included on the eye exam). If you do not prefer this, check decline

❑ **Accept** ❑ **Decline**

Please be advised if you are using insurance coverage for today's visit, this is a contract between you and your insurance company...not Edgewater Eyecare.
If your insurance company has not reimbursed our office in full within 60 days, you are responsible for providing payment in full to Edgewater Eyecare.

Patient Signature: __________________________
Date: __________________________