New Lenox Family Eyecare Ltd.

Thank you for choosing us for your eye care needs. Please take a moment to complete and review the information below to ensure that is accurate.

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Sr. ☐ Jr. ☐ III

Patient _____ _____ _____ _____
First Name Last Name MI Preferred Name

Address _____

City _____ State _____ Zip code _____

Home Phone _____ Cell Phone _____ Other Phone _____

What is your preferred contact number? ☐ Home ☐ Cell ☐ Text ☐ Email

Last four of SSN _____ Email _____ Birthday _____

Occupation _____ Gender ☐ Male ☐ Female Employment Status ☐ Employed ☐ Full Time Student ☐ Part Time Student

Marital Status _____ Employer/School Name _____

Guardian (if minor) and relationship _____

Primary Insured on Account (if not above patient)

Name _____ _____ _____
Last First MI

Patient's relationship to Insured ☐ Spouse ☐ Child ☐ Other

Gender ☐ Male ☐ Female Address _____

City _____ State _____ Zip Code _____ Phone Number _____

Birthday _____ Last four of SSN _____ Employer/School Name _____

Vision Insurance

Insurance Name _____

Insurance ID# _____ Insurance Group# _____

Medical Insurance

Insurance Name _____

Insurance ID# _____ Insurance Group# _____

Secondary Medical Insurance

Insurance Name _____

Insurance ID# _____ Insurance Group# _____

How were you referred to our office?

- ☐ Patient (please name) _____
- ☐ Doctor (please name) _____
- ☐ Other (please name) _____

Health History

When was your last eye exam? _____ When was your last health exam? _____

Have you or anyone in your immediate family been diagnosed with any of the following?

	Self	Family
Diabetes	Yes / No	Yes / No
Heart Disease	Yes / No	Yes / No
Ear, Nose, Throat Disorders	Yes / No	Yes / No
Respiratory Disorders	Yes / No	Yes / No
GI, Kidney Disorders	Yes / No	Yes / No
Muscle, Bone, Joint Issues	Yes / No	Yes / No
Skin Disorders	Yes / No	Yes / No
Neurological Disorders	Yes / No	Yes / No
Thyroid Disorders	Yes / No	Yes / No
Autoimmune, Blood	Yes / No	Yes / No
Hypertension	Yes / No	Yes / No

Other _____

Do you or anyone in your immediate family have any of the following eye conditions?

	Self	Family
Amblyopia (Lazy Eye)	Yes / No	Yes / No
Blindness, Vision Loss	Yes / No	Yes / No
Cataracts	Yes / No	Yes / No
Color Deficiency	Yes / No	Yes / No
Glaucoma	Yes / No	Yes / No
Macular Degeneration	Yes / No	Yes / No
Retinal Issues	Yes / No	Yes / No
Strabismus (Eye Turn)	Yes / No	Yes / No
Eye Diseases	Yes / No	Yes / No
Other Eye Issues	Yes / No	Yes / No

Are you experiencing any of the following symptoms?

Foreign Body Sensation, Irritation	Yes / No	Double Vision	Yes / No
Glare	Yes / No	Floaters, Spots, Flashing	Yes / No
Dry Eyes	Yes / No	Blurred Distance Vision	Yes / No
Eye Pain	Yes / No	Blurred Near Vision	Yes / No
Itching	Yes / No	Discharge	Yes / No
Headaches	Yes / No	Redness	Yes / No

Other _____

Current Medications: _____

_____

Eye Medications: _____

Allergies to Medications: _____

Environmental Allergies: _____

Surgeries or Illnesses: _____
(include date)

Primary Care Physician: _____ _____
Name Clinic

_____ _____
Phone Address

Spectacle Lens History

Do you currently wear glasses? Yes / No If yes, how old are they? _____

How many hours a day do you use a computer? _____

How far away is your computer screen? _____

Do you wear sunglasses? Yes / No Are your sunglasses your prescription? Yes / No

Contact Lens History

Do you currently wear contacts? Yes / No If no, are you interested in contacts? Yes / No

How many hours a day do wear your contacts? _____

What kind of solution do you use? _____ How often do you replace your contacts? _____

Do you use nutritional supplements? Yes / No
Do you engage in regular exercise? Yes / No
Do you drink alcohol? Yes / No

Do you use tobacco products? Yes / No
Do you use illegal drugs? Yes / No
Are you pregnant or nursing? Yes / No

What is your preferred language? _____ What is your ethnicity? _____

What are you hobbies/interests? _____

Professional and material fees are due by the patient when services are rendered, unless other arrangements are made in advance. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Accounts 60 days old are subject to collection fees. There will be a service charge on all returned checks.

Payment from my insurance is to be paid directly to New Lenox Family Eyecare Ltd.. I understand that billing any secondary insurance is my responsibility. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed.

My signature below also acknowledges I have been offered/received a copy of New Lenox Family Eyecare Ltd.' Notice of Privacy Practices. We will gladly provide eyeglass and contact lens prescriptions upon your request.

_____ _____

Patient/Guardian Signature Date